3400.00.00 BUDGETING AND BENEFIT CALCULATION

This chapter discusses the budgeting of income, income deductions, and the calculations necessary to determine financial eligibility. Specific information includes:

Income Budgeting Principles (Section 3405);
Budgeting Self-Employment Income (Section 3410);
Budgeting Boarder Income (Section 3415);
Rental Income (Section 3420);
Budgeting Striker's Income (Section 3425);
Budgeting Educational Income (Section 3430;
Lump Sum Calculation (Section 3435);
Budgeting Expenses (Section 3440);
Benefit Calculation (F) (Section 3445);
Benefit Calculation (C) (Section 3450;
Benefit Calculation (MED 1) (Section 3455);
Benefit Calculation (MED 2, 3) (Section 3460);
Benefit Calculation (MED 4) (Section 3465);
1619 Medicaid Budgeting (Section 3475);
Buy-In Procedures and Effective Dates (Section 3480); and
Footnotes for Chapter 3400 (Section 3499).

3405.00.00 INCOME BUDGETING PRINCIPLES

Financial eligibility is based on the best estimate of income and circumstances which will exist in the month for which the assistance is being considered. This estimate should be founded upon the most complete information available to the Local Office as of the authorization date. This eligibility determination requires knowledge of an individual's and/or AG's current, past or anticipated future circumstances. A presumption that current or historical trends will continue in the future cannot be made. Use of historical trends is appropriate if there is reason to believe, with supporting documentation, that the trends will continue.

Prospective budgeting rules require that the AG's assistance for a given month be based on the income expected to be received during that month. (f1) For Medicaid, actual income is budgeted for each of the three retroactive months prior to the month of application. (f1A)

To calculate monthly amounts, the frequency and budgeting method of the income must first be determined.

3405.05.00 INCOME FREQUENCY

Frequency is defined as how often income is received. Amounts may be received weekly, bi-weekly, semi-monthly, monthly, quarterly, semi-annually, annually, or less often than monthly. The codes used in ICES to correspond to these frequencies are WK, BW, SM, MO, QT, SA, AN, and LO.

3405.10.00 BUDGET METHODS

Once the frequency of an income is determined, the method of budgeting the amount is determined.

The following sections list the various budget methods and the circumstances under which they are used.

3405.10.05 Regular Budget Method

Regular income is income received in the same amount each pay period with no variances.

The monthly amount is determined using the appropriate conversion factor as follows: (f2)

> The gross amount of income received weekly is to be multiplied by 4.3.
>
> The gross amount of income received biweekly is to be multiplied by 2.15.
>
> The gross amount of income received semimonthly is to be multiplied by 2.

Enter the amount of the income which corresponds to the frequency; the ICES calculator will convert it to a monthly amount.

3405.10.10 Fluctuating Budget Method

Income which varies each pay is to be converted to a monthly amount using the "fluctuating budget method" unless the client requests that the "averaging" method be used.

Fluctuating (F) method:

> The payments received during the months being reviewed are added together and the total is divided by the number of payments; then, the appropriate conversion factor as explained in Section 3405.10.05 is applied. A pay which is unusually high or unusually low should not be included in the calculation. The budget method "S-SKIP" should be entered for a pay which is not reflective of what can be expected to be received in the future.

If "S-SKIP" is used in an application month, the pay amount will be included for the application month calculation but will be skipped for months past the application month.

3405.10.15 Averaging Budget Method

The Average (A) budget method may be used with income received weekly, bi-weekly, semi-monthly or monthly. Averaging may only be used when complete monthly amounts are available and there are two or more months of history.

Migrant AGs applying for Food Stamps may not have their income averaged.

An AG has the option of choosing this budget method. However, if complete monthly amounts are not provided, it may not be used.

3405.10.20 Prorated Budget Method

The Prorated (P) budget method distributes an income over the period of time associated with the income or expense. This budget method is only used with the frequency LO - less often than monthly. Educational income is a common example of income which is often calculated using this frequency and budget method. This is also the only budget method with which it is appropriate to enter the begin and end date on ICES. This entry is used by the ICES calculator to determine how many months by which to divide the income amount. This budget method is not used for earned income.

3405.10.25 Beginning/Terminating Budget Method

Income is projected when an individual has just begun working, has changed jobs, or has had a change in rate of pay. If the person has just begun to work, verified earnings to the date of the budget computation are to be used. Otherwise, an estimate of anticipated earnings can be obtained from the employer and used as a basis for projection on a monthly basis.

When the 'B' budget method is used, that budget month will use all the 'B' income or expenses as actual 'B' amounts with no conversion. The system will take the last entry only and convert it for any subsequent month. If the 'B' method is left, the system will continue to budget for future months converted by the appropriate frequency. If the beginning pay is not reflective of future months, a new amount and budget method must be entered.

The 'B' budget method should only be used if all of the following 3 statements are true about the income (or

expenses):

The job is a new job or the source of income is new, and

The income will not be received for every frequency (a full month's income) in the month the job/income source begins, and

The same month the income source begins also needs to have this income included (new job starts in October, income of new job is budgeted for October) in the budget for that month. This usually would occur at a new application point or for add a program.

EXAMPLE:

A client applies on 7/10 with a new appl and has a job where he will receive his first pay on 7/22. The worker verifies the information with the employer that the client will receive a partial pay of $50 and then $100 a week there after. The income on AEINC should be listed as follows:

RCVD DATE	FREQ	BGT MTD	GROSS AMT
07/22	WK	B	50.00
07/29	WK	B	100.00

July's budget will be $150 (50 + 100) and August and thereafter will be $430 (100 X 4.3)

If this same situation was new information reported at a 7/10 redet, these pays would then be listed as 'S' for the first pay and 'R' for the second pay since all 3 criteria for the 'B' budget method were not met. (3rd criteria not met as the July budget is already in effect without the new earnings.)

While rare, the client could report at a 7/10 redet that he will be starting a job in August and will be paid bi-weekly with the only one check being received in late August. The worker would correctly project the one actual pay for August since the August budget is not in effect yet and this situation meets the criteria for using the 'B' budget method. (Notice this is not a new application or add a program situation where most 'B' situations will occur.)

RCVD DATE	FREQ	BGT MTD	GROSS AMT
08/22	WK	B	100.00

August would be budgeting $100 (actual) and September would be budgeting $430 (100 X 4.3).

When an employed person loses his employment, which includes being laid off or on strike, an evaluation is to be made of the expected length of time without income.

If the period without income is expected to be at least one month, a new budget showing loss of income is to be computed. This is done by using the 'T' budget method. An entry must be made for each anticipated source of income (or expense) in the last month that it is expected to be received. The system will add up each 'T' entry and use the actual amount for that budget month if the budget month is

not in effect yet. No 'T' entry is ever carried into the budget beyond the month it was received.

EXAMPLE:

The client reports on 10/20 that he will only be working until the end of the month and will receive 2 more pays in November for $100 each. The income should be listed on AEINC as follows:

RCVD DATE	FREQ	BGT MTD	GROSS AMT
11/1	WK	T	$100
11/8	WK	T	$100

If the worker authorizes this before the 11/1/ pulldown, the November budget will reflect $200. If authorized after pull-down, no income will appear in the December budget. An auxiliary benefit would be needed for November (calculated manually).

3410.00.00 BUDGETING SELF-EMPLOYMENT INCOME

Self-employment budgeting procedures are outlined in the following sections. Self-employment income is generally determined by subtracting allowable expenses from the gross income. The income and expenses are entered on AEISE.

3410.05.00 DEFINITION OF SELF-EMPLOYMENT

The determination of whether an individual is self-employed will generally be verified by federal income tax returns and there is no need to further question the existence of a trade or business. However, in some instances, it may be necessary to inquire further into the situation to determine if a person is self-employed when tax returns are not a definitive measure. Consider the following when determining that a person is self-employed:

The good faith intention of making a profit or producing income as a regular occupation;

The holding out to others as being engaged in a business of selling of goods or services;

The continuity of operations or regularity of activities;

The lack of an “employer” relationship in the regular sense of the word in which the employer pays wages and or provides benefits;

The existence of documentation in the person’s possession that supports his or her claim of self-employment;

Being a member of a business or trade association;

A single factor is not always sufficient to determine whether a person is self-employed, nor must all of the above factors be met. Caseworkers must apply the factors listed as well as others that may exist, to determine whether an income producing activity is self-employment. In some cases it may be necessary to distinguish self-employment from a hobby. Also persons working as contractors or subcontractors may or may not be self-employed.

A person is not self-employed if he or she receives a W-2 form showing wages paid, the employer pays FICA taxes, or the person is paid a salary from a corporation or individual.

The net profit from self-employment income may be determined through a review of past books or records of the previous year's Federal Income Tax Report. The method of determining the net profit is to be documented in the case record.

IRS regulations are not used in all programs in determining whether a given expense is deducted as an expense in the calculation of self-employment income. (Not all of the expenses listed on tax returns can be allowed as self-employment costs for all programs when a self-employed individual files an income tax return.)

3410.10.00 ESTABLISHING ANNUAL SELF-EMPLOYMENT INCOME

Current income from self-employment may be determined by using the individual's tax return filed for the previous year if a review of his current business records indicates no substantial variance. If the previous year's tax return is not an accurate reflection of current income, his recent records are to be used to project the annual income.

When the individual is engaged in a new business, he must supply business records for his taxable year-to-date and annual income is to be projected.

When he is engaged in a new business and records are not yet available or the business has been going on for some time but no records were kept, annual income is determined by using the individual's best estimate. For Medicaid and TANF, if approved for assistance, the individual must keep records and after no longer than two months actual income must be verified. For Food Stamps, if the AG is subject to simplified reporting rules, the AG must report only if the

actual income exceeds 130% of the gross income limit for the AG. However, if the AG reports new verification for TANF and/or Medicaid after two months, the new income is also included in the Food Stamp budget.

Seasonal self-employment income which is intended to meet the household's needs for only part of the year should be prorated over the period of time the income is intended to cover. For example, clients who are self-employed only during the summer months to supplement their annual income will have their summer self employment income prorated over the summer months.

For Medicaid seasonal employment, including self-employment is annualized to establish a monthly amount.

3410.15.00 ALLOWABLE SELF-EMPLOYMENT COSTS

Allowable costs of producing self-employment income differ depending on the program.

Examples of allowable costs for all programs are:

- wages, commissions, and mandated costs relating to the wages for employees of the self-employed;
- the cost of shelter in the form of rent, the interest on mortgage or contract payments, taxes, and utilities;
- the cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments;
- insurance on the real and/or personal property involved;
- the cost of any repairs needed; and
- the cost of any travel required. If the actual cost cannot be determined, 25 cents per mile may be used to calculate the expense. The number of miles must be verified to allow the 25 cents per mile.

For Food Stamps expenses which are not allowable costs of doing business include income net losses from previous periods, work related expenses covered by the 20 percent earned income deduction and depreciation. When calculating the costs of producing self-employment for Food Stamps either the greater deduction, 40% of the gross income or actual verified expenses directly related to the production of income is used unless the business involves boarders or day care.

When calculating the income for Food Stamp boarders, either the maximum food stamp allotment for a household size that

is equal to the number of boarders or actual costs is deducted as a cost of business.

When calculating the income for Food Stamp clients who are day care providers, use either the actual costs or the amounts used in the Child and Adult Care Food Program which are $0.98 for breakfast, $1.80 for lunch or supper or $0.53 per snack or a State Standard of $3 per day as a cost of doing business. These determinations must be made off-line and entered on ICES as a cost of doing business.

Actual expenses for items other than the cost of food and meals can be used in addition to the state standard and child and adult care food program prices.

Food Stamps also allows payments on the principal of the purchase price of income producing real estate and capital assets. Capital assets may be vehicles, real property or equipment used in the self-employment business.

For categories of assistance C, MED 2, and MED 3 the AG may have either the greater deduction, 40% of the gross income or actual verified expenses directly related to the production of income, deducted. (f4)

For all categories of assistance in MED 1 and 4, except MA R, allowable expenses include those allowable under the Internal Revenue Code from gross income. (f5)

Net profit is the total income derived from a self-employment enterprise less allowable deductions.

3410.20.00 HOME USED FOR SELF-EMPLOYMENT (F)

When a room of an AG's home is used only for a self-employment enterprise, a portion of the interest paid on the mortgage and utilities if the AG is not using a Standard Utility Allowance are allowable business costs. The portion is calculated as follows:

> One room of a six room house is used only for business; 1/6 of the interest and 1/6 of utilities are calculated off-line and are listed on screen AEISE and deducted from the self-employment income. The remaining 5/6 of the interest and utilities are listed on screens AEFSC/AEFUC and allowed as a shelter expense.
>
> The full phone standard is allowed as a self-employment deduction when there is a phone in the room used for the self-employment enterprise.

When the FS AG qualifies for either Standard Utility Allowance #1 or Standard Utility Allowance #2 and does choose an SUA, a utility expense cannot be deducted from the

self-employment income. The chosen SUA is listed only as a utility expense on screen AEFUC; a utility expense is not listed on screen AEISE. However, if the home is equipped with two meters, one for the AG's residence and one for the self-employment enterprise, the AG may chose to use a SUA or actual expenses for the residence. The actual utility bills are deducted from the self-employment income. The AG would not be entitled to use a standard utility allowance for the residence as well as a standard utility allowance for the self-employment enterprise in this situation.

3410.25.00 FARM LOSS BUDGETING (F)

If the cost of producing self-employment income exceeds the income derived from self-employment as a farmer, such losses are offset against any other countable income received by the AG. Losses from farm self-employment enterprises are offset in two phases. The first phase is an offsetting against nonfarm self-employment income. The second phase is offsetting against the total of earned and unearned income.

For purposes of this provision, to be considered a self-employed farmer, the farmer must receive or anticipate receiving annual gross proceeds of $1000 or more from the farming enterprise. If less than $1000 annual gross income is anticipated, the farm loss calculation is not considered.

3415.00.00 <u>BUDGETING BOARDER INCOME</u> (F)

Boarder income is entered on AEIRB. The income from boarders includes all direct payments to the AG for room and meals, including contributions to the AG's shelter expenses. (f6)

Shelter expenses paid directly by boarders to someone outside of the AG are not counted as income to the AG.

> NOTE: This does not include the income of payments made to persons in foster care who are considered boarders for Food Stamp purposes when they are not included in the AG.

3415.05.00 BOARDER COST OF BUSINESS (F)

After determining the income received from the boarders, the portion of the boarder payment which is a cost of doing business is excluded as income. The cost of doing business is equal to one of the following, provided that the amount allowed as the cost of doing business does not exceed the payment the AG received from the boarder for lodging and meals.

> The maximum Food Stamp allotment for an AG size that is equal to the number of boarders; or

The actual documented cost of providing room and meals, if the actual cost exceeds the maximum Food Stamp allotment. If actual costs are used, only separate and identifiable costs of providing room and board to the boarder are excluded.

3415.05.05 Net Boarder Income (F)

The net income from self-employment is added to other earned income and the 20% earned income deduction applied to the total. Shelter costs the AG actually incurs, even if the boarder contributes to the AG for part of the AG's shelter expenses, is computed to determine if the AG will receive a shelter deduction. However, the shelter costs must not include any shelter expenses directly paid by the boarder to a third party, such as the landlord or utility company.

3415.10.00 BUDGETING ROOMER AND BOARDER INCOME (F, MED 1, 4)

The policy stated in this section does not apply to MA R.

In a roomer and boarder situation, net rental income is determined by deducting allowable expenses (see Section 3420.05.05) proportionately to the number of rooms (excluding bathrooms) in a private house or by the number of people living in the house. Examples of roomer and boarder situations are as follows:

The applicant owns a seven room house (excluding bathrooms) and rents one bedroom. The roomer pays $100 a month. All allowable expenses equal $400 a month. One-seventh of those expenses ($57.14) is deducted from gross rental income. $42.86 is budgeted as net rental income.

The applicant and his wife have a five room house (excluding bathrooms) and rent one room with meals provided. The roomer and boarder pays $200 a month. Allowable income producing costs equal $200 a month and food costs equal $300. One-fifth of $200 = $40. One-third of $300 = $100. $140 is deducted from gross rental income. $60 is budgeted as net rental income.

3420.00.00 <u>RENTAL INCOME</u>

Rental income is payment for the use of real or personal property. Rental payments may be received for the use of land (including farm land), for land and buildings, for a room, apartment, or house, or for machinery and equipment.

3420.05.00 BUDGETING RENTAL INCOME

Rental income may be considered either unearned or earned income. Regardless, for all programs, income from rental property is determined by the costs of doing business being deducted from the gross income.

For F: Rental income is unearned unless a member of the AG is actively engaged in the management of the property at least an average of 20 hours per week. If the income is earned, the 20% earned income disregard is subtracted from the gross.

For C, MED 2, and MED 3 categories of assistance: Rental income is unearned unless the production of income includes some type of personal involvement and effort on the part of an AG member.

For MED 1 and 4 (except MA R): Rental income is unearned income unless the AG owns multiple rental properties so that there is a rental business; that situation is considered self-employment earned income.

ICES determines whether the income is unearned or earned for each program based upon answers to questions on AERPI.

3420.05.05 Allowable Rental Expenses

Allowable rental expenses include most costs allowed by the Internal Revenue Service.

Examples of rental expenses allowed are:

Property taxes;
Interest payments;
Repairs;
Advertising expenses;
Lawn care;
Insurance premium for property only;
Trash removal expenses;
Snow removal expenses;
Water;
Utilities; and
Other necessary expenses.

The following costs are allowed by the Internal Revenue Service, but are not allowable deductions for all assistance programs:

Depreciation;
Payments on mortgage principal;
Personal expenses of the owner;
Insurance to pay off the mortgage in the event of death or disability; and
Capital expenditures.

3425.00.00 BUDGETING STRIKER'S INCOME (F)

The following section outlines the policy relating to budgeting striker's income for Food Stamps.

3425.05.00 DEFINITION OF STRIKER (F)

For Food Stamp purposes, a striker is anyone involved in a strike or concerted stoppage of work by employees (including a stoppage by reason of the expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees. Any employee affected by a lockout, however, should not be determined to be a striker. Further, any individual exempt from work registration in accordance with Section 2438.00.00 (other than those exempt solely on the grounds that they are employed) who may go on strike should not be determined to be a striker.

If an AG member is a striker according to the above definition, apply the criteria below to determine if the AG member is a striker for the budget month:

The AG member is a striker if on strike the last known point in the month; or

The AG member is not a striker if:

- he would have been exempt from Work Registration for a reason other than employment (such as child under age six) on the day prior to the strike;
- is unable to work because other related professions are on strike;
- is not a part of the bargaining unit on strike;
- will not cross the picket line due to fear of injury or death;
- is fired or officially resigns from his job; or
- is replaced by permanent employees hired by the company.

3425.10.00 DETERMINING STRIKER'S INCOME (F)

Determining striker's income is done by comparing his prestrike income with his current income. To determine prestrike income, use only the income of the striker prior to going on strike. This is entered on AEIEI. If the month is not over, anticipate the amount the striker would have received for the month had he not gone on strike. To determine the current income amount, anticipate the amount

the striker will actually receive for the month on AEINC. ICES then compares the striker's prestrike income to his current income and the higher of the two is used as the striker's income. (f7)

To determine eligibility and benefit amount, the striker's income is added to the current income of nonstriking AG members and the total compared to the appropriate income limits.

3430.00.00 BUDGETING EDUCATIONAL INCOME

If an AG member has both exempt and non-exempt income (see Sections 2860.05.00 and 2860.10.00), allowable educational expenses are deducted from exempt income first. All remaining allowable expenses are then deducted from the non-exempt income. If any non-exempt income remains, it is prorated over the number of months it was intended to cover and counted as unearned income. **Note:** The second step only applies to non-exempt educational income received directly by the student. If the entire amount is received and retained by the school, it is completely excluded from the budgeting process. If the school receives the income directly and refunds any unused portion to the student, only the refunded amount is budgeted as unearned income (after allowable additional educational expenses are deducted).

EXAMPLE:

Mr. Smith is a graduate student. His verified educational income and expenses are listed below:

Financial Aid	Educational Expenses
$3000 Perkins Loan (Exempt income)	$4000 Tuition, fees
	$ 500 Books, supplies
$3500 Kiwanis Scholarship (Non-exempt income)	$ 100 Transportation
	$ (Actual)

Step One: Subtract expenses from exempt educational income:

$3000
- 4600
- $1600 (unmet educational expenses)

Step Two: Establish what portion, if any, of the non-exempt scholarship money is accessible to the student. It has been verified that the scholarship funds are sent directly to the school. The financial aid office verifies that a refund check for $2500 will be sent to Mr. Smith. $1000 of the total scholarship money is excluded from consideration since it was retained by the school and is not available to the recipient/student. This leaves $2500 available non-exempt income.

Step Three: Subtract the unmet expenses in Step One ($1600) from the remaining non-exempt income:

$2500 available non-exempt educational income
- 1600 unmet educational expenses
$ 900 countable educational income is prorated over the month it was intended to cover and budgeted as unearned income to the AG.

The income and resources of persons determined to be ineligible students for Food Stamps are not considered in determining eligibility or level of benefits of the Food Stamp AG.

3430.05.00 ALLOWABLE EXPENSES FROM EDUCATIONAL INCOME

Allowable expenses for undergraduates and graduate students include tuition, mandatory fees, supplies, books and transportation. Mandatory fees include the costs of rental or purchase of equipment, materials and supplies related to the pursuit of the course of study involved for all programs. Transportation is allowed at 25 cents per mile if the actual cost cannot be determined. For Food Stamps, dependent care amounts made available for dependents by the

grantor can be excluded on AEFEE. If the grantor does not identify a specific amount for dependent care, the student can claim actual expenses which will be entered on AEFDE and allowed up to $175 per dependent over age two and $200 per dependent under age two per month. The worker must ensure that dependent care expenses allowed on AEFEE are not included on AEFDE.

Miscellaneous personal expenses (other than normal living expenses) are also allowable deductions if they are incidental to attending the school, institution or program. Such expenses could include such things as subscriptions to educational publications or dues for a professional association. Normal living expenses which are not allowable would include such items as food, rent, board, clothes, laundry, haircuts and personal hygiene items.

For Food Stamps, students attending vocational and technical schools and those attending a program in which a high school diploma, or equivalent is received, may also receive expenses from educational income.

In addition to those listed above, for Food Stamps, allowable expenses also include insurance premiums on loans and personal expenses necessary to the course of study.

3435.00.00 NON-RECURRING LUMP SUM PAYMENT CALCULATIONS (C, MED 2, MED 3)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

Non-recurring lump sum income received on the date of application or after by a person whose income is counted in the eligibility determination is counted as income in the month received. The lump sum provision (as discussed in Section 2880.10.00) does not apply when the lump sum payment is received by a non-mandatory non-participating member of the AG (for example, a step-parent, or a parent whose income is deemed in the Medicaid determination for a pregnant minor parent). Those individual's lump sums are budgeted as income in the month received, as with any other income.

The non-recurring lump sum period of ineligibility does apply when the lump sum is received by a mandatory non-participating AG member (for example, a sanctioned parent). If the non-recurring lump sum income and all other countable income for the month exceeds the AG's income standard, a period of ineligibility is calculated. The ineligibility period always begins with the month in which the lump sum was received. (Often, the first month or two of ineligibility will be determined after-the-fact, resulting in an overpayment situation for those months.) Detailed information on determining the length of the period of

ineligibility is provided in Sections 3435.05.00 through 3435.25.00.

3435.05.00 NON-RECURRING LUMP SUM PAYMENT EXEMPTIONS AND DISREGARDS (C)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

When lump sum income is received by a participating AG member, a period of ineligibility is calculated. (T9) To determine the countable amount of lump sum income, the following exemptions and disregards are allowed:

applicable earned income disregards if the lump sum is from earned income;

a settlement or judgment that is earmarked and used for the purpose for which it is paid; for example, moneys for back medical bills resulting from an accident or injury, funeral or burial costs, replacement or repair of resources (when the resource would be exempt as a resource), or legal fees;

compensation received for replacement of lost, stolen, damaged, or destroyed real or personal property (when the real or personal property would be exempt as a resource);

an inheritance which is received by a beneficiary and is used for the burial expenses of the deceased benefactor;

federal or state income tax refunds;

refunded security deposit paid on rental property or utilities;

payment deposited in a guardianship account which is unavailable;

property or funds received resulting from a dissolution of marriage;

back pay of Supplemental Security Income.

3435.10.00 DETERMINING INITIAL PERIOD OF INELIGIBILITY (C)

The AG will be ineligible for assistance for the full number of months for which a lump sum payment should meet the AG's total monthly needs based on the corresponding income standard.

The period of ineligibility is calculated as follows:

The countable lump sum income is combined with the AG's other countable monthly income after applicable disregards; and

The total countable income is divided by the income or need standard for the recipient's category of assistance for the number of people whose needs are taken into account in determining the AG.

The number of full months determined by this calculation equals the lump sum period of ineligibility. Any income remaining is counted as unearned income in the first month following the ineligibility period. (f10)

EXAMPLE:

A two member Cash AG with no other income receives a $5000 insurance settlement on June 6 resulting from an automobile accident and personal injury. The legal fees incurred are $1000. The caseworker is to:

Subtract total expenses of $1000 from the $5000 lump sum;

Determine the period of ineligibility by dividing the countable lump sum ($4000) by the total need standard ($255) of the AG.
($4000 / $255 = 15 months of ineligibility with $175 remaining.)

The AG is ineligible for 15 months and assistance is discontinued effective July 1. An overpayment is calculated for June.

Once the period of ineligibility is calculated, a notice is sent to the AG specifying the period of ineligibility and listing the four situations for shortening the period discussed in the following sections.

3435.10.05 Shortening Ineligibility Period (C)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

There are four situations under which the period of ineligibility must be recalculated to determine if the period of ineligibility can be shortened. If multiple situations occur, multiple recalculations must be done.

3435.10.10 Life Threatening Circumstances (C)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

For the purpose of determining the shortened period of ineligibility, life threatening circumstances are defined as: (f11)

emergency or other necessary medical care for any member of the AG; or

replacement of lost, stolen, damaged, or destroyed real or personal property excluded as a resource.

The period of ineligibility is shortened if: (f12)

the applicant declares, under oath, that the income was used, prior to the onset of life threatening circumstances, to meet essential needs; and

the remaining income has been or will be expended in part or in full in connection with these life threatening circumstances; and

the AG currently has insufficient income or resources to meet these life threatening circumstances.

3435.15.00 EVENT AFFECTS NEED STANDARD (C)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

The period of ineligibility must be shortened when an event occurs which, had the AG been receiving assistance for that month, would result in:

an increase in the AG's standard of need; and

an increase in the amount of assistance payable for that month.

The only event which will result in an increase in both the need and payment standard of an ineligible TANF AG is the addition of a TANF eligible AG member.

When an individual becomes part of a TANF AG which is serving a period of ineligibility due to prior receipt of a lump sum payment, that individual is not subject to the ineligibility period. However, that person's needs, during the months for which TANF is not granted, could be considered to shorten the period of ineligibility of the AG.

The recalculation is done as of the month the change occurs. The initial step is to determine the total amount of the lump sum income remaining in that month. This is done by

multiplying the old income standard by the number of months of the ineligibility period already used and then subtracting this figure from the lump sum income. The remainder is then divided by the new, increased income standard applicable to the month in which the change occurred. The applicant is ineligible for the additional number of months resulting from this division. Any income remaining after this calculation is unearned income in the first month following the period of ineligibility.

3435.20.00 LUMP SUM INCOME BECOMES UNAVAILABLE (C)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

If the lump sum income has become unavailable to the AG for reasons beyond their control, the period of ineligibility must be shortened. (f13)

Unavailable for reasons beyond their control is defined as a situation in which the AG loses the legal ability to have and use the income at their discretion through a circumstance that is not a deliberate act on their part to deplete the lump sum payment. Examples include theft substantiated by a police report or retrieval of the payment by the payor.

The Local Office must carefully document any situation of unavailability. It may be necessary to consult the Local Office attorney to resolve questions of legal availability. Complete facts will also be necessary to the Local Office's determination of whether or not the unavailability is for reasons beyond the AG's control.

If the AG claims the lump sum income has become unavailable, an immediate determination of the validity of such claim must be made. If, in fact, the lump sum income is unavailable for reasons beyond the AG's control, the period of ineligibility ends immediately.

3435.25.00 MED EXPENSES DURING INELIGIBILITY PERIOD (C)

Within the programs designated above, this policy applies only to the following categories: ADCR, ADCU, ADCI.

Medical expenses must be considered if they were incurred and paid during the ineligibility period by any member of the AG, nonrecipient parents, nonrecipient stepparents, and nonrecipient children. (f14)

Medical expenses are defined as any expense resulting from treatment for or prevention of physical or mental conditions. Qualifying expenses include, but are not limited to, those covered by the Medicaid program.

Medical expenses used to shorten the ineligibility period must be verified.

The total medical expenses are first subtracted from the total income used to determine the original period of ineligibility. This difference is then divided by the need or income standard to determine the new full number of months of ineligibility from the original discontinuance date. Any remainder again becomes income in the first month following the period of ineligibility. A notice specifying the new period of ineligibility is sent to the applicant.

3435.30.00 BUDGETING LUMP SUM INCOME (MED 1, MED 4)

The policies stated in this section apply to the MA A, MA B, MA D, MA G, MA L, MA J, MA I, and MA K categories of assistance.

A lump sum includes such items as retroactive RSDI or VA benefits, refunds of Medicare Part B premiums, and inheritances. A lump sum is considered as income in the month of receipt. An SSI lump sum is disregarded as income in the month of receipt.

3435.30.05 Lump Sum Income (MED 2, MED 3)

A lump sum is only income in the month received and is exempt as income for subsequent months.

3437.00.00 CONTRACT SALE OF REAL PROPERTY

For Food Stamps and the MED 1 and 4 categories, when property is sold on contract, the monthly land contract payments, less ownership expenses, are counted as income. Payments received on a basis other than monthly are to be prorated to establish a monthly amount.

For the C, and MED 2 and 3 categories, any payment of interest received as a result of the sales contract (including that portion of any periodic payment) is to be budgeted as unearned income in the month of receipt.

The portion of the periodic payment that represents payment toward the principal is considered a non-exempt resource.

3439.00.00 CONTRACTUAL INCOME (F)

Contractual income that is a household’s annual income (intended to provide support for the household for the entire year), and is not paid on an hourly or piece work basis, should be prorated over 12 months. Contractual income that is not the household’s annual income (intended to provide support for the household for only a portion of the year), and is not paid on an hourly or piece work basis,

shall be prorated over the period the income is intended to cover. For example, clients who receive contractual income only during the summer months to supplement their annual income will have their contractual income prorated over the summer months. (See 3420.00.00 for budgeting contractual income received from self-employment. Contractual income that is from the sale of real property is addressed in 3437.00.00.

Contractual income received other than monthly (for example, quarterly, semi-annually or annually) should be prorated over that period to establish a monthly amount.

3440.00.00 BUDGETING EXPENSES (F)

The following sections outline which expenses are allowable and the correct policy for budgeting expenses.

3440.05.00 DEPENDENT CARE EXPENSE/DEDUCTION (F)

Expenses for dependent care for a child or other dependent which are incurred and paid by an AG member and are necessary for the member to seek/accept/continue employment or attend training/education in the amount of the actual cost up to $200 a month for each child under two and $175 a month for each other dependent. If the expense for a dependent exceeds the maximum, the excess may not be added to the expense for another dependent which is less than the maximum. (f15)

If the child reaches his or her second birthday during the certification period, the $175 a month amount will be effective no later than the rescheduled redetermination.

Dependent care expenses covered by payments from Step Ahead voucher agents and other government agencies are not allowed as deductions.

If the expense qualifies as both a dependent care and a medical expense, the expense is counted as a medical expense.

3440.05.05 Dependent Care Expense/Disregard (MED 2, MED 3)

Wage earners are allowed an earned income disregard of all out of pocket child care expenses (up to the maximum standards listed in section 3015.10.00) for all dependents or incapacitated adults living in the same home as the child receiving assistance. (f16)

3440.05.10 Dependent Care Expense/Disregard (C)

Employed TANF recipients are allowed to disregard all out of

pocket dependent care expenses (up to the maximum standards listed in Section 3015.10.00) for incapacitated adults or children in the home only when the AG would be ineligible for cash assistance without the disregard. If the TANF AG is eligible without the disregard the expense, no disregard is given. If the TANF AG fails and the employed recipient has a dependent care expense, the disregard would be applied.

3440.06.00 CHILD SUPPORT DEDUCTION (F)

Child support payments paid by a Food Stamp AG to a non-AG member are considered as an allowable deduction if the payments have been ordered by the court.

The deduction may be allowed if the payment is made to an individual or agency outside the household even if the child for whom the support is paid is an AG member. For example, if the payment is being made to IV-D, the deduction would be allowable.

No deduction is allowed if the payment is made to another AG member.

A deduction is to be allowed for any legally obligated Child Support, whether paid directly to the household or as a vendor payment. For example, Child Support that is provided in-kind, such as payment of rent directly to the landlord would also be eligible as a deduction if it is court ordered.

Arrearage payments may be included in the deduction if anticipated to continue. The support order or separation agreement does not have to require payment of arrearages.

The AG must provide verification that the payments have been ordered by the court as well as proof that payments are being made in order for a deduction to be given.

The AG may use an average of prior month payments as a determining factor in which to base the amount of the deduction. The DECB screen may be used to verify past months payments. The AG is not required to report fluctuations in the amount of the support received within the certification period when an average has been used to determine the amount of support in the budget. However, the worker must act on changes that the AG voluntarily reports.

If a past history of payments does not exist, the deduction will be based on the obligated amount.

At redetermination, verification must be obtained of changes in the legal obligation, including the amount of the

obligation and the amount of child support the AG member pays.

Unchanged information must not be verified at redetermination unless the information is incomplete, inaccurate, inconsistent or outdated.

AG’s which contain all elderly and/or disabled members and have a 12 month certification are required to report changes in the legal obligation to pay child support.

If the allowable child support deduction is paid by an ineligible member, the deduction is divided by all AG members (including the ineligible member) and all but the ineligible members share is counted as deduction in the Food Stamp budget.

3440.10.00 SHELTER EXPENSES/DEDUCTIONS (F)

Allowable shelter deductions are listed in the following sections. Allowable deductions include continuing charges, taxes, assessments, insurance, and utility expenses.

3440.10.05 Continuing Charges (F)

Continuing charges for the shelter occupied by the AG including rent, mortgage, or other continuing charges leading to the ownership of shelter, such as loan repayments for the purchase of a mobile home, including interest on such payments, are allowed as deductions. Condo and association fees are also allowable shelter expenses.

Continuing charges include second mortgages or "home equity loans" as they are commonly known. Regardless of the terminology used or the purpose of the loan the determining factor is whether the loan is secured by a lien placed on the property by the lending institution. Payments on secured loans meet the criteria of continuing changes for the shelter, and are considered shelter costs. Payments made on unsecured, or "personal" loans are not considered shelter costs. Loans provided under the Homestead Act are also allowable as they are considered to be continuing charges that lead to ownership of the shelter. Under the Homestead Act, homes are given to households and loans are provided so the shelter can be repaired.

3440.10.10 Property Taxes, Assessments, Insurance (F)

Property taxes, state and local assessments, and insurance on the structure itself are allowed as deductions. Separate costs for insuring furniture or personal belongings are not allowed as deductions. If structure/content insurance cannot be separated, the entire premium is allowed.

Service charges for installment payments of insurance premiums are not allowable.

3440.15.00 UTILITY DEDUCTION OPTIONS (F)

Effective April 1, 1996, there will be four utility deduction options for AGs that qualify. These options must be explained to all AGs that report utility expenses or receipt of an Energy Assistance Payment (EAP). As of 4/1/96, the Utility Deduction Statement, Form FI-2425 must be completed for all AGs at application/reapplication, at redetermination and whenever a change in utilities is reported. The original statement must be reviewed at each redetermination and whenever the AG's circumstances have changed. If the AGs choice remains the same, the original can be updated with the CW's and AG's initials.

If the AG selects another option at any time, a new statement must be completed. If the person who signed the original statement leaves the AG, a new statement must be completed at the next determination.

The AG cannot be penalized for failure to complete, sign or return the Utility Deduction Statement. Therefore the CW must complete the form with the AG's choice and document that the statement was completed by the CW. A copy should be mailed for the client to sign and return for changes not reported in person but change processing must continue according to guidelines in Section 2220.

3440.15.05 Actual Utility Expenses (F)

The actual cost of utilities may be allowable as a deduction. Actual utility costs include the cost of fuel for heating and cooling, electricity used for purposes other than heating or cooling, water, sewerage, septic tank system installation and maintenance, garbage and trash collection fees, and fees charged by the utility provider or telephone company for initial installation of the utility. Deposits and late fees may not be included as shelter costs.

If the AG has a security light, the expense is allowed only if the bill is for the electricity used and not a rental charge for the light itself. Verification from the utility company must be obtained to determine whether or not the expense is allowable. If the rental charge cannot be divided out, the entire expense is allowable.

If the AG has propane gas and is charged a fee for rental for the propane tank, both the cost of the gas and the rental fee for the tank, even if shown separately on the bill, are allowable shelter costs.

Each actual current utility expense must be listed on AEFUC. The most current bill received at the date of the interview including taxes should be budgeted. Amounts carried forward from a past billing period are not to be listed.

Verification of each expense must be listed. "CS" is not an acceptable verification. If the AG has recently moved and has not received a bill at the current address, the AG may obtain an estimate of the expense from the utility company or from the landlord to be used as verification.

An AG may waive the right to provide utility verification and have benefits calculated without the utility expense(s). The Utility Deduction Statement is to be completed and signed by the AG.

If the AG selects actual utilities and has not provided verification of amounts by the deadline, but verification of a primary heating/cooling, EAP assistance, or electric expense has been previously verified at the current address, the appropriate Utility Standard is to be used. When actual expenses are received, they must be budgeted for the next month.

If the AG has not provided verification of actual utility amounts or an expense that qualifies the AG for a standard, AEABC must be run and the expenses(s) not allowed as a deduction.

If an AG member is disabled, screen AEIDP must be properly coded in order for the system to allow the uncapped shelter deduction.

3440.15.10 Standard Utility Options Available (F)

Two Standard Utility Allowances (SUA) are available effective 4/1/96.

In order to receive either SUA the AG must not share utility expenses with another AG or non assistance family. This restriction applies to AGs which contain an ineligible student with whom the expense is shared.

The heating/cooling SUA1 requires that the AG has a recurring primary heating or cooling expense or that the AG receives a Energy Assistance Payment (EAP). It is not necessary that the AG have both a heating and a cooling expense. If the AG has only a heating or only a cooling expense obligation and the need for that particular expense has ended solely because the seasonal need for that expense is ended the AG continues to be entitled to the heating/cooling SUA. Also, an AG that has a room air conditioner is entitled to the SUA.

Persons in private rental housing who are billed by their landlords on the basis of individual usage or who are charged a flat rate separately from their rent are eligible for the heating or cooling standard (SUA1).

Persons in public housing units which have central utility meters and which charge households only for excess heating or cooling costs are not entitled to the heating/cooling standard (SUA1).

Some AGs may receive EAP assistance although they have no out-of-pocket utility expenses or only a non-primary heating and cooling expense. These AGs are eligible for SUA1 the entire year if they receive an EAP payment during the heating season. Use the list of EAP recipients provided by CAAP to verify eligibility for these AGs during the summer months (April-November) when the program is not operational.

Because EAP funding and eligibility guidelines vary from year to year there is no reasonable way to anticipate an EAP payment from year to year. Individual EAP funding limits are set for each county. When funds are spent, applications are no longer taken. When applications are accepted, they must be processed within 10 days. When AGs without out-of-pocket expenses or primary heating and cooling expense have not received EAP at their current address, they cannot be allowed the SUA until EAP is approved.

If a previous EAP payment was used to verify the AGs entitlement to the SUA, the caseworker should send himself/herself an alert during the next heating season to verify with the CAAP agency that the AG continues to receive EAP.

Households that receive direct or indirect energy assistance that is excluded from income consideration (other than EAP) are entitled to the SUA1 only if the amount of the expense exceeds the amount of the assistance, that is, they have an out of pocket expense. Households that receive direct or indirect energy assistance that is counted as income and incur a heating or cooling expense are entitled to the SUA1.

The heating/cooling SUA includes average gas, electricity, water, sewer expenses and the telephone standard.

The non heating/cooling SUA2 includes electricity and fuel for purposes other than heating or cooling, water, sewerage, well and septic tank installation and maintenance, telephone and garbage or trash collection. In order to qualify for the SUA2 the AG must be billed for at least two of the expenses included in the SUA2.

If an SUA option, excluding the telephone standard option, is chosen, no actual utility costs may be budgeted. See Manual Section 3020.00.00 for the Utility Standard amounts.

3440.15.10.05 Switching A Utility Option (F)

AG's that qualify for a choice of utility deduction options (actual or one of the SUA options) may switch options at any of the following points.

at initial certification;

at redetermination; or

when a household moves

The SUA must be disallowed when the AG is no longer eligible for the SUA. Advance notice of adverse action must be given if removal of the SUA decreases benefits. Changes in utility expenses, receipt of EAP and sharing at the same address are not required to be reported during the certification period. If a change is reported it must be acted on and any reported change in non-AG household members should be followed up with questions about shared expenses.

A new Utility Deduction Statement must be completed whenever another option is selected.

3440.15.15 Prorating Actual Expenses (F)

If actual utility expenses are the selected option, expenses shared with other AGs or non recipients must be prorated.

Each AG may be allowed the amount paid on each allowable expense.

or, if the amounts actually paid cannot be differentiated the expense is prorated evenly among all persons paying and only the AG member(s) share(s) are allowed in the FS budget.

Actual expenses of ineligible aliens/SSN disqualified members of the AG must be prorated over the entire AG. The alien/SSN members expenses must be divided by the number of AG members and a share deducted for each alien/SSN member. The remaining expense is included in the AGs budget.

3440.15.15.05 Prorating SUA Within The AG (F)

If an AG shares expenses with another AG or nonrecipient, or an ineligible student the SUA will not be allowed. Therefore proration of the SUA will only occur within the AG when expenses are shared with or paid by a AG member who is an ineligible alien or SSN disqualified.

If the ineligible alien/SSN sanctioned member pays the entire expense or any portion of the expense, the SUA will be divided by the number of AG members, including the ineligible alien/SSN members. A share will be deducted for each ineligible alien/SSN member from the SUA. ICES will calculate this proration correctly if all persons in the AG paying any part of the utilities, are listed on AEFUC.

If the alien/SSN disqualified persons do not pay any portion of the expenses the AG may receive the entire SUA if otherwise eligible.

Proration within the AG is not necessary when IPV, IMPACT and Work Registration disqualified members are present because all of their income and expenses are included in the budget calculation.

If expenses are shared with, or paid by an ineligible student who would otherwise be an AG member, the SUA will not be allowed. If the ineligible student does not share or pay any of the utility expenses the AG may receive the entire SUA if otherwise eligible.

3440.15.20 Caseworker Responsibilities Regarding Utilities (F)

The worker must thoroughly explain the utility options, including what makes an AG eligible for an SUA, which expenses are included in the SUA, proration within the AG and when the AG can change options. The worker must assist the AG to complete the Utility Deduction Statement and enter the correct information on AEFUC. The worker should document on CLRC what makes the AG eligible for the option chosen. The worker should review AEBFN and explain the result of any proration to the AG.

As stated in Section 3440.15, the CW must re-evaluate eligibility for the SUA at each redetermination but verification is not required unless a change is reported or a new option is chosen. The CW must verify the AG's entitlement to an SUA option when:

1. An SUA option is first chosen at application, recertification or when a change occurs.

2. A change in the qualifying expense, EAP, or sharing arrangement is reported.

3. A change of address is reported.

Only reverify the circumstance that has changed. When a change in household composition is reported the CW must ask about sharing.

EXAMPLES

1. AG moves in with non-recipients at new address and claims SUA1 because the AG pays all utilities

   Verify - sharing arrangement, qualifying expense or EAP.

2. AG receiving SUA1 reports non-recipients moving into home and AG continues to pay all utilities.

   Verify sharing (qualifying expense or EAP - already verified at recert) with updated Utility Deduction Statement (UDS).

3. AG1 moves in with AG2. AG2 and AG1 already receiving SUA1.

   Verify sharing with updated (UDS) Utility Deduction Statement for both AGs.

   If they now share expense, request actual expenses and discontinue SUA with notice. If one AG pays all expenses, allow that AG the SUA and remove all Expenses for the other AG.

4. AG receiving SUA1 reports moving to subsidized housing where rent is $100.00 and all utility expenses included in rent.

   Verify eligibility for EAP with CAAP and expenses by viewing lease.

3440.15.25 Entering Utility Deductions In ICES (F)

In order to enter utility expenses in ICES, AEFSQ is first completed. This screen contains questions regarding the AG's choice of actual or standard utility amounts. It is at this point that the worker must explain all utility options to the AG and assist the AG in completing the Utility Deduction Statement. See Manual Section 3440.15.00 for instructions.

If the AG selects an SUA, entering Y in the SUA field on AEFSQ will bring up AEFUC.

Complete all questions about actual utility expenses on AEFSQ with the client's response.

Enter the number of the AG member who pays utilities or receives EAP at the top of AEFUC.

Enter the AGs answer to: Do you share utility expenses with anyone not in the AG? If the answer is yes, the SUA options would not be allowed.

Select the appropriate SUA option and enter a ? mark until verified.

List all members of the AG who pay a share of the utilities so ICES may prorate and deduct expenses of ineligible aliens and SSN disqualified persons. At least one member of the AG must be listed if an SUA option is selected. If receipt of EAP qualifies the AG for the SUA, you must list one member as a "payor".

If the AG has selected an SUA option complete all detail fields for the expense that qualifies the AG for the SUA.

The due date and amount can be omitted for expenses listed but not verified because the SUA was chosen. Put a ? in the verification field so the AG will pend if the SUA is later disallowed.

The same SUA option must be chosen on all AEFUC screens for all case members because the SUA options are not allowed if other non-AG members share the household expenses.

If AEFUC screens are completed with different answers to the SUA questions an error message will be generated before you leave AEFUC. Authorization will be prevented by a code on AEWAA if the error is not corrected.

Document on CLRC how eligibility for the SUA was determined. For example, gas heat is the primary heating expense or, an EAP payment was received. EAP payments should also be listed on AEFAI.

3440.15.30 HUD Utility Payments (F)

HUD rent and utility payments are exempt as income. Any HUD payments made to AGs should be shown on AEFAI.

The HUD payments should be deducted from the actual expense and only the excess portion the AG must pay is to be deducted on AEFSC or AEFUC. (ICES does not make the deduction with the information from AEFAI).

CLRC should document the explanation for the deduction.

3440.20.00 TELEPHONE EXPENSE (F)

An AG which incurs a basic service fee for telephone (including a cellular phone) and has not chosen the Standard Utility Allowance option is entitled to the Standard Telephone Expense of $27. Actual expenses for telephone

service are not allowed. For AGs which choose the Standard Utility Allowance, the telephone expense is not allowed because the telephone expense is included in the Standard Utility Allowance.

AG's which share the basic service fee and have not chosen the SUA are to have the telephone standard amount prorated evenly between all AG's which share the expense (both participating and non-participating). This requires an off-line proration calculation with the prorated amount entered on AEFUC. The total of all shares must not exceed the telephone standard amount.

The cost of special telephone equipment for the handicapped is allowed as a medical expense.

3440.25.00 SHELTER EXPENSES OF UNOCCUPIED HOMES (F)

All shelter costs stated above may be allowed for the home if it is not actually occupied by the AG because of one of the following reasons:

employment or training away from the home;
illness;
abandonment of the home due to natural disaster; or
casualty loss.

If a home is unoccupied because of employment or training away from home, illness, a natural disaster or casualty loss, actual utility costs for the occupied and unoccupied homes or the appropriate SUA for the occupied residence only is allowed.

For the costs of a vacated home to be included in shelter costs:

the AG must intend to return to the home;

the home must not be leased or rented in the AG's absence.

the current occupants of the home, if any, must not be claiming the shelter costs for Food Stamp purposes during the absence of the AG; and

AGs claiming utility costs for unoccupied homes must verify the actual expenses if actual costs are budgeted. The AG may also select the SUA; however, if the AG selects the SUA for the unoccupied home only one SUA can be allowed in the budget for both the occupied and unoccupied homes.

Since there are few cases with both occupied and unoccupied homes, the ICES system has not been modified to accept the SUA for an unoccupied home. If the situation arises in

which the AG wishes to use the SUA for the unoccupied home and actual expenses for the occupied home, the worker will have to indicate on AEFUC the SUA for the occupied home (system will not allow the SUA for unoccupied). The actual expenses from the occupied home are then entered. The budget will then include the total of both the SUA and the actual expenses. The correct information is then documented and explained on CLRC.

If the entire AG moves in the middle of a month and there are shelter expenses for two residences, the costs from both residences are allowable (both actuals or 1 SUA).

An SUA may not be used, however, if the AG splits and one member moves, that member cannot have a deduction from the residence from which he moved.

3440.30.00 REPAIR COST EXPENSES (F)

Charges for the repair of the home which was substantially damaged or destroyed due to a natural disaster such as a fire or flood are allowable as a shelter deduction. Shelter costs may not include charges for repair of the home that have been or will be reimbursed by private or public relief agencies, insurance companies, or from any other source. Only the nonreimbursed costs of repairs are allowable.

3440.35.00 RESERVED (F)

3440.40.00 VERIFICATION OF SHELTER EXPENSES (F)

Each AG must claim and verify the dates and amounts of the allowable expenses when the AG elects to use the actual amount of the expense. If the AG opts to use the standard, verification of a primary heating or cooling expense or receipt of a LIHEAA payment must be obtained. If the AG requests actual utility bills to be budgeted, but fails to provide verification, the standard is to be budgeted provided eligibility for the SUA has been verified.

Homeless AGs may not be able to provide the normal verification of shelter expenses. If a homeless person reports shelter expenses for several nights but is unable to provide verification, the caseworker must use good judgment to decide if verification is adequate or otherwise obtainable. If the costs reported are comparable to the costs incurred by others in the community, the caseworker may decide to accept the household's statement as adequate verification. The caseworker may anticipate expenses and allow the SSE based on the verification.

3440.45.00 ALLOWABLE MEDICAL EXPENSES FOR FOOD STAMPS (F)

This section lists allowable medical expenses and how they are used in the eligibility determination for Food Stamps.

Medical expenses in excess of $35 which are incurred by AG members who are elderly (60 or over) or disabled are allowed if the expenses are not paid by Medicaid and not subject to payment by a third party. This means that if an expense is reimbursable by a third party such as health insurance, it is not an allowable expense. The difference between the amount paid by the third party and the amount of the expense is allowable. Note, in this context the Medicaid program is not a third party. For additional FS budgeting information, refer to Section 3440.45.05.

Special diets are not allowable medical expenses.

Allowable medical expenses include the following:(f19)

1. Medical and dental care, including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by state law or other qualified health professional;

2. Hospitalization or outpatient treatment, nursing care, and nursing home care. For Food Stamps, payments by the AG for an individual who was an AG member immediately prior to entering a hospital or nursing home provided by a facility recognized by the state are allowed. (The AG must not have been on assistance prior to entering for the expense to be allowed.)

3. Prescription drugs when prescribed by a licensed practitioner authorized under state law and other over the counter medication (including insulin) when prescribed by a licensed practitioner or other qualified health care professional. The cost of postage incurred by the individual for mail-order prescriptions is also an allowable medical expense.

4. Medical supplies and durable medical equipment.

5. Health and hospitalization insurance policy premiums. Premiums for health and accident policies such as those payable in lump sum settlements for death or dismemberment, or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled, are **not** allowed. The premiums paid for

indemnity policies are not allowed since indemnity policies do not limit benefits and the purposes for which benefits can be used.

If the insurance premium includes AG members not eligible for the deduction and the eligible AG member's portion cannot be broken out, prorate the premiums among all insured AG members and allow only the portion for the eligible AG member(s).

6. Medicare Part A and Medicare Part B premiums which are paid by the individual; For Medicare recipients on Buy-In, the state pays their premiums and, therefore, the premiums are not allowable in the FS budget.

7. Home health care is a medical expense provided by a licensed health care professional.

8. Dentures, hearing aids, prosthetics, and eyeglasses (including repairs) prescribed by an ophthalmologist or optometrist.

9. Actual verified cost of transportation necessary to obtain medical care or items that are allowable expenses.

   If the person has driven his own car, and cannot prove the actual cost, 40 cents per mile is allowed.

10. The Medicaid co-payment. This is a nominal fee assessed to certain Medicaid recipients for prescription drugs, non-emergency visits to a hospital emergency room, and transportation services.

11. Services approved for a recipient under one of the Medicaid Home and Community-Based Services (HCBS) waivers, except case management and home-delivered meals.

12. The M.E.D. Works Premium.

13. Cost of purchasing/renting an air conditioner and other equipment which are not considered medical supplies or durable medical equipment, but are prescribed by a qualified health care professional;

14. Costs associated with securing and maintaining any animal specially trained to serve the needs of disabled persons such as seeing eye dogs, hearing

guide dogs, and housekeeper monkeys trained to assist quadriplegics;

15. Lodging expenses spent to obtain medical treatment or services;

16. Cost of an attendant, homemaker, child care services, or housekeeper necessary due to age, infirmity, or illness. If the AG furnishes the majority of the attendant's meals, an additional medical expense is allowed equal to the maximum one person Food Stamp benefit allotment.

17. The Medicaid liability paid by the client when he is residing in a Medicaid certified group living arrangement.

18. Payments made on an old bill that has not been previously counted in the Food Stamp budget.

19. Home repairs and remodeling costs to accommodate a disabled person (example-ramps or handrails).

20. Expenses for an individual who was or would have been an AG member immediately prior to entering the hospital or nursing home.

21. Special telephone equipment related to medical needs.

3440.45.05 Medical Expenses In The Food Stamp Budget (F)

An allowable medical expense is deducted in the FS budget if the person who incurs the medical expense is elderly or disabled as defined in Section 3210.10.25.05. The amount of the medical expense deducted in the FS budget depends upon whether the person with the medical expense has been determined eligible for FS only; for FS and regular Medicaid; FS and Medicaid with a spend-down; or FS with Medicaid under QMB-only. The total amount of the medical expense that exceeds $35 and is not reimbursable by a third party is allowed in the FS budget. If a medical expense is reimbursable, only the difference between the amount of the expense and the amount of the reimbursement can be allowed in the FS budget. The types of medical expenses which are allowed in the FS budget are listed in Items A and B of Section 3440.45.00. The following discusses how expenses are included when all members of the FS AG receive FS only (Example #1); when the member of the FS AG who incurs the medical expenses is also participating in a regular Medicaid AG (Example #2); when a member of the FS AG who incurs the medical expense is also participating in a Medicaid AG with a spend-down (Example #3); when a member in the FS AG who

incurs the medical expense is also participating in a QMB-only Medicaid AG (Example 4).

For elderly or disabled individuals who receive Food Stamps only, the Food Stamp budget will include all allowable medical expenses listed in items A and B of Section 3440.45.00 which exceed $35. These expenses are indicated in ICES by a Y in the FS column of Table TMEE. Table TMEE is Field Level Help for the TYPE field on screen AEFME. See Example #1. However, if a medical expense has been listed as reimbursable on screen AEFME, the amount of the medical expense will not be included in the FS budget until the amount of the reimbursement is entered on screen AEFME. Once the amount of the reimbursement has been entered, the difference between the amount of the expense and the amount of the reimbursement is allowed in the FS budget when the amount exceeds $35 see Example #1.

EXAMPLE 1

Client A receives Food Stamps only, he has the following medical expenses, all are coded with a Y in the FS Column of Table TMEE:

$75 durable medical expense (monthly)
$200 eyeglass expense (one time only)
$50 prescription (monthly)

The Food Stamp budget will include $75 + $200 + $50 = $325 - $35 = $290. The following month the $200 one time only expense will be removed and the $75 + $50 = $125 - $35 = $90 medical expense will be budgeted.

(The AG could have also had the one time only expense prorated over the cert period which would have to be completed by a fiat if the client is also on Medicaid.) See Section 3440.65.05.

For elderly or disabled individuals who receive Food Stamps and regular Medicaid (no spend-down), the Food Stamp budget will include all medical expenses which are allowed for FS only and medical expenses not covered by Medicaid which exceed $35. However, if a medical expense has been listed as reimbursable on screen AEFME, the amount of the medical expense will not be included in the FS budget until the amount of the reimbursement is entered on screen AEFME. Once the amount of the reimbursement has been entered, the difference between the amount of the expense and the amount of the reimbursement is allowed in the FS budget when the amount exceeds $35. The Food Stamp only medical expenses are coded on Table TMEE with a Y in the FS column; N in the MED column and N in the FS/MA column of Table TMEE. Some of

these expenses are Medicaid co-payment, lodging expenses to obtain medical treatment or services and securing and maintaining a helping animal. Medical expenses not covered by Medicaid are coded with a Y in the FS column; Y in the MED column and Y in the FS/MA column of Table TMEE. Some of these expenses are Medicare Part B premium which is paid by the individual and health and hospital insurance premiums. See Example #2.

EXAMPLE 2

Client B receives Food Stamps and Medicaid. There is no spend-down. She has the following medical expenses, prescription, physical therapy and doctor visits are coded as Y Y N on Table TMEE. The health insurance is coded as Y Y Y.

$125 prescriptions (monthly)
$50 physical therapy expense (monthly)
$60 doctor visit expense (monthly)
$45 health insurance premium (monthly)

The Food Stamp budget will include the health insurance premium only, $45 - $35 = $10 because Medicaid will pay for the remaining medical expenses.

For elderly and disabled individuals who receive both Food Stamps and Medicaid and have a spend-down the following expenses which exceed $35 will be included in the Food Stamp budget in the following order:

1. All FS only expenses (coded Y N N on Table TMEE).

2. All non-Medicaid covered expenses (coded Y Y Y on Table TMEE).

3. Medicaid covered expenses which are coded with a Y in the FS column; Y in the MED column and N in the FS/MA column of Table TMEE. These expenses are allowed up to the spend-down or the portion of the spend-down not met by non-Medicaid covered expenses in step #2. Example #3 explains this budgeting.

If any of the above medical expenses are listed as reimbursable on screen AEFME, the amount of the medical expense will not be included in the FS budget until the amount of the reimbursement is entered on screen AEFME. Once the amount of the reimbursement has been entered, the difference between the amount of the expense and the amount of the reimbursement is allowed in the FS budget when the amount exceeds $35.

EXAMPLE 3

Mr. C receives Food Stamps and Medicaid. Mrs. C, his wife, age 60, receives Food Stamps but does not receive Medicaid.

Mr. C has a $270 spend-down.

Mr. and Mrs. C have the following medical expenses:

$100 prescriptions (monthly) not reimbursable -- Mr. C;

$100 prescriptions (monthly) not reimbursable -- Mrs. C;

$80 health insurance premium (monthly) -- Mrs. C.

The Food Stamp budget will include the following in this order:

1. None of the medical expenses are FS only expenses (coded Y N N on Table TMEE). The calculation of the medical expense would begin with Step #2.

2. All non-Medicaid covered expenses which is the $80 health insurance premium;

3. The non-Medicaid covered health insurance expense of $80.00 does not equal the spend-down amount, therefore, $190 of the prescription expense is added to the $80.00 health insurance premium; for a total of $270 - $35 = $235 in the FS budget.

There are five (5) expenses on Table TMEE which are allowable for meeting the Medicaid spend-down but are not paid by Medicaid after the spend-down is met. These expenses are allowed in the Food Stamp budget regardless of the spend-down amount. These include Health Insurance premiums, Medicare Part B premiums (self-pay), non-Medicaid covered expenses (NM), expenses denied prior authorization by Medicaid and an old bill that has not been previously counted in the Food Stamp budget. These expenses are coded as Y Y Y on Table TMEE.

When a Food Stamp AG has any of these five (5) expense types <u>and</u> has a spend-down, they should be encouraged to use these expenses to meet the spend-down rather than expenses that will be paid by Medicaid (coded as Y Y N on Table TMEE). This will ensure that the clients out-of-pocket expenses

(which must be included in the FS budget) do not include expenses that could have been paid by Medicaid.

The spend-down amount is not an allowable expense in the Food Stamp budget.

The Medicare Premium Part B (self-pay) is always an allowable expense in the Food Stamp budget. The possibility that it may be paid or bought-in by the State does not make it a reimbursable expense.

Transportation and other medical services provided by neighbors or other non-Medicaid approved providers must be coded as "NM", non-Medicaid covered expense, to allow the actual out-of-pocket expenses in the Food Stamp budget.

If the FS AG member who has medical expenses is on the Medicare Savings Program as QMB-only (not full coverage Medicaid), Medicare covered services are not allowed in the FS budget because any out of pocket expense such as the coinsurance and deductibles will be paid by Medicaid. On TMEE, these expenses are shown as 'Medicare covered'.

EXAMPLE 4

Mrs. B. has FS and QMB-only Medicaid coverage. Her medical expenses are as follows:

$135 in prescriptions

$500 in monthly oxygen rental (Medicare covered)

$100 ($135 minus the $35 threshold) is allowed in the FS budget because Mrs. B. has no out-of-pocket expense for the oxygen.

3440.46.00 ALLOWABLE MEDICAL EXPENSES FOR MEDICAID (MED 1, 2)

Within MED 1, this policy applies only to the MA A, MA B and MA D categories of assistance. Within MED 2, it applies to the MA Q category of assistance.

This section lists allowable medical expenses for the eligibility determination for Medicaid and reflects the Medicaid eligibility rule change, 405 IAC 2-3-10, regarding treatment of medical expenses subject to payment by a third party that was implemented January 1, 2006.

Medical expenses incurred by the applicant/recipient and financially responsible relatives are allowed in the eligibility step if income exceeds the applicable income standard. Expenses are also deducted in the post-

eligibility step as explained in Section 3455.15.10. Refer to Section 3440.46.05 for additional information on budgeting of medical expenses, and to Section 3455.10 for spend-down eligibility

Medical expenses are allowed whether or not the medical provider is certified to participate in the Medicaid program.

Allowable medical expenses are listed below. (f19a)

1. Medical care provided by physicians, psychiatrists, and other licensed medical practitioners;

2. Laboratory testing, x-rays, and other diagnostic procedures;

3. Dental services including dentures provided by a licensed dentist;

4. Hospitalization and outpatient treatment;

5. Nursing facility services and rehabilitative services;

6. Respiratory, occupational, speech, physical, and audiology therapy services;

7. Prescription drugs and over the counter medication (including insulin) when prescribed by a licensed medical practitioner who is authorized under State law to prescribe legend drugs. For Medicare beneficiaries, this includes drugs that are excluded from coverage under Medicare Rx. Excluded drugs **include** barbiturates, benzodiazepines, and over-the-counter drugs that are Medicaid covered. A Prescription Drug Plan may choose to cover a Medicare excluded drug, in which case the cost of the drug is not an allowable medical expense in the Medicaid budget. An excluded drug under Medicare Rx is different from a non-formulary drug. Refer to the list of non-allowed medical expenses at the end of this section.

8. The cost of postage incurred by the individual for mail-order prescriptions;

9. Medical supplies if ordered in writing by a licensed physician or dentist for treatment of a medical condition;

10. Durable medical equipment if ordered in writing by a licensed physician;

11. Home health care provided by a licensed home health agency;

12. Nursing services provided by a registered nurse or licensed practical nurse;

13. Audiology services and hearing aids if ordered in writing by a physician;

14. Prosthetic devices other than those dispensed for purely cosmetic purposes, if ordered in writing by a physician, optometrist, or dentist;

15. Vision care services, including eyeglasses, examinations, and diagnostic procedures;

16. Cost of transportation to obtain medical services that are allowable medical expenses. If transportation is provided by a business transportation carrier, the verified carrier's charge will be allowed. If the individual or friend, or family member drives the individual to medical services, mileage costs is allowed at the rate per mile established for state employee business travel. Currently this amount is $.40 per mile.

17. The premium of the recipient's spouse who is on MED Works (MADW);

18. Co-payments required by other health insurance that covers the individual, including Medicare Rx co-payments. The Medicaid co-payments are allowable medical expenses when the recipient is satisfying spend-down and will be credited to spend-down by the AIM system when the claim is filed by the provider. However, in the eligibility determination, an extra amount for the co-pay is not allowed since it is included in the cost of the service.

19. Health and hospitalization insurance policy premiums. Premiums for health and accident policies such as those payable in lump sum settlements for death or dismemberment, or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled, are **not** allowed. The premiums paid for indemnity policies are not allowed since indemnity policies do not limit benefits for the purpose of reimbursing medical expenses.

If the insurance premium includes AG members not eligible for the deduction and the eligible AG member's portion cannot be broken out, prorate the premiums among all insured AG members and allow only the portion for the eligible AG member(s).

The amount of any allowable health insurance premium is deducted in the eligibility determination and reduces the amount of the AG's spend-down.

20. Any waiver service approved for the individual who is approved under one of the Medicaid Home and Community-Based Services (HCBS)

    Caseworkers must verify the specific services that are approved under the Medicaid waiver for an individual. Local offices should check with their Area Agency on Aging, appropriate waiver case manager, or BDDS District Office to obtain the documentation of approved waiver services for an individual.

21. Targeted case management services provided to pregnant women, individuals with HIV, and individuals receiving services from a community mental health center under the Medicaid rehabilitation option.

Non-allowable expenses include the following:

1. Special diets and nutritional supplements;

2. Emergency response systems;

3. Non medical home care such as companions, attendants, homemakers, etc.

4. Home and vehicle repairs/modifications to accommodate a handicapped individual.

5. For Medicare beneficiaries, drugs that are not on the Prescription Drug Plan's formulary.

3440.46.05 Medical Expenses In The Medicaid Budget (MED 1, 2)

This section applies to MA A, MA B, MA D, and MA Q and reflects the Medicaid eligibility rule change, 405 IAC 2-3-10, regarding treatment of medical expenses subject to payment by a third party that was implemented January 1, 2006.

Medical expenses are included in the Medicaid budget whenever the AG's countable income is more than the income standard. Medical expenses of the applicant/recipient and his spouse, whose income is included in the budget, are

considered. If the applicant/recipient is a child under age 18 living with parents whose income has been included in the budget, the parents' medical expenses are considered. Any expense that is subject to payment by or paid by a third party that is not a state or local program is not allowable. In this context a state or local program is one which is 100% funded by state or local funds. After the third party has adjudicated the claim, the amount that is allowable in the Medicaid budget is the difference between the expense and the reimbursed amount. In other words, the allowable amount is the individual's out of pocket expense.

Refer to Section 3440.46.00 regarding allowable expenses, 3440.47.00 regarding ICES entry, and Chapter 3600 regarding spend-down determinations.

3440.47.00 ENTERING MEDICAL EXPENSES IN ICES (F, MED 1, 2)

This section reflects the Medicaid eligibility rule change, 405 IAC 2-3-10, regarding treatment of medical expenses subject to payment by a third party that was implemented January 1, 2006.

Medical expenses must be correctly entered on AEFME to be reflected in the Food Stamp and Medicaid budgets. Any amount of an expense that is shown as the reimbursable amount on AEFME will be deducted from the total amount of the expense to be included in the Food Stamp budget or the Medicaid budget. For Medicare covered services, the "Medicare approved amount" is the amount of the expense to enter, not the provider's private rate. This amount is discernable on the provider bill to the patient and also on the Medicare Summary Notice that the individual receives. Amounts shown as "Medicare write off" are not allowed in the budget. If the provider does not know the Medicare approved amount, the amount that the provider would charge a non Medicare beneficiary is to be entered. This will likely happen if a bill is presented to the caseworker prior to adjudication by Medicare or other insurance. In this situation the verification code for both the expense and the reimbursable amount must be entered as question marks. Follow regular program verification guidelines. For Medicaid, if it necessary to deny an application or discontinue benefits due to the worker not receiving verification of third party payments or medical expense amounts, caseworkers are to use the special reason code 237. Use of the general failure to cooperate reason code is not appropriate. For Food Stamps, if the worker does not receive verification of a third party payment or medical expense amount, the expense is disallowed.

When Medicaid is a program choice, the caseworker must enter all medical expenses incurred in each of the three months

prior to the month of application. Use the appropriate Budget Method and Frequency so that the ICES calculator will use the ongoing expenses to determine eligibility in the application month forward. Additionally, expenses incurred prior to the three-month retroactive period which are ongoing, such as a semi-annual expense, are to be entered. Expenses which are expected to be incurred in the recur month and are documented are also to be entered. Caseworkers should use the Medical Expense Worksheet, to help in determining the ongoing and anticipated expenses, separate from one-time expenses. Expenses that are one-time expenses must be entered as such so that they are not budgeted as ongoing expenses.

The unpaid balance of an old bill should not be entered on AEFME unless the AG does not have enough ongoing expenses to be eligible for Medicaid. If it is necessary to enter the unpaid balance because the MA AG's average ongoing medical expenses do not exceed the surplus income, use code "UB" as the type and "monthly regular" for frequency and budget method. Make an expected change entry on AEFEC if it is expected that the balance will be used in full for spend-down purposes prior to the next redetermination. Once an unpaid balance has been used in full to meet spend-down, it must be deleted on AEFME. If the client is making payments on an old bill, enter the payment as type "PO".

For the post-eligibility budget, payment of an old bill which is not subject to payment of a third party and is not covered by Medicaid is an allowable deduction. This expense is coded on AEFME as NM, a non-covered Medicaid expense. The amount that will be paid each month is the amount to allow.

3440.48.00 VERIFICATION OF MEDICAL EXPENSES (F, MED 1, 2)

Verification of medical expenses will include the type and amount of the expense, the date the expense is incurred, whether or not it is reimbursable by a third party, and the reimbursed amount. For bills on which a monthly payment has been arranged, verification must be obtained from the provider to prove the arrangement.

Medical expenses and third party reimbursed amounts can be verified by the following:

Bill from a provider;
Receipt from a provider;
Written statement from a provider; and/or
Telephone contact with the provider, as a last resort.

Verification must show whether a third party has or will be billed, and if a third party has paid, the amount of the

payment must be shown so that the caseworker can determine the individual's out-of-pocket expense.

Medicare or other insurance reimbursement can also be verified by the Medicare Summary Notices that Medicare sends to beneficiaries and other explanation of benefit notices from insurance payers.

3440.50.00 EXPENSES NOT ALLOWED AS DEDUCTIONS (F)

An expense covered by excluded reimbursements or vendor payments shall not be deductible. This would include rent or utility expenses paid by exempt HUD payments (see 2835.15.05 and 2845.55.00). The portion of the rent or utility expense covered by HUD is not calculated as part of the shelter or utility deduction. (f20)

> **EXAMPLE:**
>
> The AG's rent is paid by a relative who is not an AG member. The relative pays the rent directly to the landlord. The rent payment is not counted as income to the AG nor is it allowed as a shelter expense.

Expenses are only deductible if the service is provided by someone outside of the AG and the AG owes a money payment for the service. For example, a dependent care deduction is not allowed if another AG member provides the care or if compensation for the care is provided in the form of an in-kind benefit such as food. Contributions made by non-recipient household members toward living expenses shared with the AG are exempt as income and the expense is not allowed (see Section 2870.05.00).

Also, expenses covered by in-kind earnings which are not countable (See Section 2815.05.00) are not allowed as deductions.

> **EXAMPLE:**
>
> The AG "works off" $200 of their $400 rent. The landlord verifies he would not give the AG the option to receive the $200 in cash. In this situation, the FS budget would not count the $200 as income. The $200 portion of the rent covered by the in-kind earnings is not allowed as a deduction, only $200 is allowed as a shelter cost.

An exception to this rule is expenses paid through/by the Energy Assistance Program (EAP), formerly known as Project SAFE or HEAT (see 2835.05.00). These expenses are to be allowed as a deduction expense if the amount due is current, even though the payment is not considered as income.

3440.55.00 BUDGETING ACTUAL EXPENSES (F)

A deduction is allowed in the month the expense is due, regardless of when the AG intends to pay the expense, unless it is a one time only or less often than monthly expense. For example, rent which is due each month is included in the AG's shelter costs, even if the AG has not yet paid the expense. (f21)

The due date is the date by which the expense should be paid that is indicated on the bill or statement. If a due date cannot be determined, consider the date the bill or statement is issued to be the due date.

Amounts carried forward from past billing periods are not deductible even if included with the most recent billing and actually paid by the AG. In any event, a particular expense may only be deducted once.

3440.60.00 ANTICIPATING EXPENSES (F)

If actual expenses are not known, an AG's expenses should be based on the expenses the AG expects to be due during the eligibility period. Anticipation of the expense should be based on the most recent month's bills unless the AG is reasonably certain a change will occur.

In the situation where the shelter has recently changed, the utility company should be asked to provide estimates for the type of dwelling and utilities used by the AG. Past expenses, such as utility bills for the last several months, should not be averaged as a method of anticipating utility costs for the eligibility period.

Medical expenses for the entire certification period must be reported and verified at the time of certification, and budgeted in the appropriate month provided the amount is based on a reasonable estimate of the expense and verification of the change is provided. (See Section 3440.45.15 regarding verifications.) If an AG reports an anticipated change at the time of certification but is unable to provide verification, the AG must be told that the expense will be allowed in the appropriate budget month when the verification is provided. If a change in medical expenses is discovered from a source other than the AG, the change is to be acted upon provided complete verification of the change is obtained without contacting the AG. If the AG voluntarily provides verification of a change, action must be taken according to Sections 2215.00.00 and 2220.00.00.

Food Stamp AG's are not required to report or verify changes in medical expenses during the certification. If a new or different expense is reported during the certification period but not verified, the expenses verified previously

will be left in the budget. Claims will not be established nor will auxiliaries be provided for AGs that do not report or verify expenses during the certification period.

3440.65.00 BUDGETING ONE TIME ONLY EXPENSES (F)

A one time only expense is an expense which the AG cannot state with certainty when the AG will be billed for again. Examples are prescriptions which are taken as needed or a fuel oil tank that is filled on as needed basis. The AG may choose to have the total expense allowed during one month or averaged over the certification period as follows.

3440.65.05 One Time Only Medical Expenses (F)

AGs with medical insurance that are entitled to the medical deduction will have the portion of their medical expenses, which have not been paid by an insurance company or another third party, considered as a one time only expense when the information about the client's share of the expense is received. This will usually be known when the statement is received from Medicare or the insurance company explaining what amount was paid and the remaining portion of the bill that is the client's responsibility to pay. When the amount paid by the 3rd party is entered in the reimbursed amount field on AEFME, the remainder of the bill will be counted.

One time only medical expenses are budgeted in one of two ways:

A one month deduction in the budget month in which the bill is due during the application process month, or the first month the caseworker will be able to allow the expense if reported as a change; or

A deduction prorated over each of the <u>rest of the months</u> of the certification period. The caseworker will prorate the expense over the period beginning with the first budget month in which the expense may be included and ending with the last budget month of the certification period. If the person with the expense also receives MED I, the Food Stamp AG must be fiated with code 153, because none of the MED I categories allow the pro-ration of one time medical expenses. If the expense is coded Y N N on table TMEE, it is a Food Stamp only expense and fiating is not necessary.

3440.65.10 One Time Only - Non-Medical Expenses (F)

All one time only expenses except medical expenses are budgeted in one of the two ways:

A one month deduction in the budget month in which the bill is due during the application process month or the first month the expense may be budgeted; or

A deduction prorated over the remaining months of the eligibility period regardless of when it is reported. The expense will be prorated over the period beginning with the next budget month of the eligibility period and ending with the last month of the eligibility period.

3440.65.15 Changes In One Time Only Expenses (F)

If the AG reports a change in a one time expense, the new expense is added to the current expenses. For example if at application the client reports a $300 fuel oil bill and the certification is for 3 months, $100 is budgeted monthly (if the AG wants the amount prorated). If during the 1st month the AG reports getting the tank filled with $150 worth of fuel, the $150 may be divided by 2, and during the 2nd and 3rd months $75 is budgeted, or the $150 all used in the 2nd month of the certification.

The worker must explain the budgeting options to the client and assist with determining which option is to the AG's advantage. For example, in the above situation, the AG asks for the 2nd bill of $150 to be pro-rated over the remaining two months of the certification period.

Because the second "one time only" fuel oil bill will be prorated over the last two months a second entry must be made on AEFUC using another utility type code. Select OT (other) as the type of expense, LO as the frequency and P (prorate) as the budget method.

CLRC should include a statement about which option the client selected.

If the AG elects to count an expense for one month only, it must be coded as frequency "OT" and budget method as "O" in order for it to be removed from the budget the following month.

3440.70.00 BUDGETING LESS OFTEN THAN MONTHLY EXPENSES (F)

A less often than monthly expense is an expense the AG can state when it will occur again, but that will not occur each month. The AG may choose to have the total expense allowed during one month or prorated as follows:

A one month deduction in the budget month the expense is due, if reported as a change or during the application process.

A deduction prorated over the period intended to cover or prorated over the interval between scheduled billings. The AG must be able to state what period the expense is intended to cover and when the next bill will be due. The caseworker will prorate the expense over the period beginning with the first month the expense is due and ending with the last month the bill is intended to cover, or the month before the next bill is due. The prorated amount will be counted in each budget month included in the proration. This may be the new certification period.

If a second billing for a type of expense coded as (LO) less often than monthly is received, the second billing may be added to the first if the same budget method is chosen and the period intended to cover is the same.

If a different budget method or the period intended to cover is different, another type code must be used as ICES will not budget 2 expenses with the same "Type" code from TSCT. Select "Other" (OT) from table TSCT and document the clients option on CLRC.

EXAMPLE: 1

If an insurance payment is intended to cover January through June, on AEFSC the frequency would be "LO" and the budget method "P". Begin date would be January 1, and the end date would be the end of June. ICES would then prorate by the six months.

EXAMPLE: 2

The same AG from Example 1 reports the purchase of another homeowners insurance policy during April. Coverage will begin in May and continue through December.

Although the frequency and budget method is the same the period covered is different. Therefore another code, OT, "Other" must be used. The frequency would be LO and the budget method P with a begin date of May 1 and end date of December 31.

3440.75.00 BUDGETING ONGOING EXPENSES (F)

Ongoing expenses are received at regularly scheduled intervals, such as monthly for most utility bills, or weekly, biweekly, and so forth. The amount of an ongoing expense which is counted is the current amount (including taxes) reported and verified at application. This amount

remains in the budget until a subsequent change is reported. If a monthly variation is anticipated, the variable amount will be used for the appropriate budget month.

Whenever an expense is received or anticipated to be received on a weekly, biweekly, or semimonthly basis for the entire month, the expense is to be converted to a monthly amount by multiplying weekly amounts by 4.3, biweekly amounts by 2.15, and semimonthly amounts by 2. (f22)

3440.80.00 VARIABLE BILLING OPTIONS (F)

Many utility companies throughout the state have billings which allow the customer to select one of different billing options. These options are given various names by the different companies including budget plans, balanced budgets, rolling budgets, etc. The client using actual utilities may select one of the optional payment amounts or the actual usage as a deduction for Food Stamps providing that past due amounts are not included. The AG may switch which method they wish to use as long as the switch does not result in past due amounts to be allowed. A switch is to be treated as a reported change and budgeted accordingly.

If an AG has a billing plan where they pay the same amount for 11 months with a reconciliation bill once a year the budget amount is allowed or the actual amount owed may be allowed if reported as a change by the AG. If a refund is received in the reconciliation month, it is to be considered a resource.

3440.90.00 SHARING EXPENSES (F)

The amount to be used when an AG/ineligible member is responsible to a third party for a shelter or utility expense, but has a nonparticipating member contribute toward the expense, is determined by subtracting the amount contributed by the nonparticipating member from the total expense. Documentation in running records comments should support the reason.

3440.95.00 EXPENSES OF DISQUALIFIED MEMBERS (F)

The entire amount of allowable medical, dependent care and shelter expenses incurred by or paid by an IPV ineligible, drug felon or Work Requirement noncompliant member is allowed as a deduction.

A prorata share of dependent care and shelter expenses which are either paid by or billed to the SSN ineligible member or ineligible alien is counted as a deduction for the remaining members. ICES makes these determinations automatically. ICES prorates the standard utility allowance based on information entered on AEFUC.

3445.00.00 BENEFIT CALCULATION (F)

The method used to determine an AG's benefit is dependent on the composition of the AG. However, all AGs are given a standard deduction. AGs with earned income are allowed an earned income deduction.

3445.05.00 STANDARD DISREGARD (F)

All AGs are allowed a standard deduction based on the household size as determined by federal regulations. The current standard amounts are listed in Section 3025.10.00. The amount is established by federal regulations and is adjusted each October. (f23)

3445.10.00 EARNED INCOME DEDUCTION (F)

Twenty percent of gross earned income is allowed as a deduction. No additional deductions are allowed from earned income except for costs of self-employment. (f24)

The earned income deduction is not allowed on any portion of income earned under a work supplementation (Grant Diversion) program that is attributable to public assistance (TANF). If there is additional money received by the client that is non-subsidized, the earned income deduction will be applied to this portion of the client's income.

3445.15.00 CATEGORICALLY ELIGIBLE AGS (F)

An AG comprised entirely of persons receiving or authorized to receive TANF and/or SSI does not have the gross or net income figure compared to the limits to determine eligibility. Such AGs are considered categorically eligible for the Food Stamp program, but may or may not receive a Food Stamp allotment. The allotment for these AGs are designated on the issuance charts. These AGs are to be suspended if not eligible for an allotment; code 022 is shown on AEWAA if the AG is categorically eligible. To authorize, SUSP must be entered. Their benefit level is determined as other AGs according to the following sections.

In addition to the income and resource information other eligibility factors deemed to be met and verified for categorically eligible Food Stamp AGs include Social Security number, sponsored alien information and residency.

3445.20.00 GROSS INCOME ELIGIBILITY DETERMINATION (F)

The total gross income of all AG members and disqualified members is the gross income. This figure will include both earned and unearned income. Exempt income is not included in this total. This gross income figure is compared to the Gross Income Eligibility Standards to determine eligibility

for AGs which do not contain an elderly/disabled member and/or is not categorically eligible.

If the AG's gross income exceeds the gross income limit for the AG size, the AG is ineligible. If the AG's gross income is below the limit, eligibility is based on the AG's net income.

3445.20.05 Net Income Calculation/AG Below Gross Income Limit (F)

The following steps outline the determination of the net income for those AGs determined to be gross income eligible:

The total gross income of all AG members is added together. This figure will include both earned and unearned income. The gross earned income (except any portion of grant diverted income) is multiplied by 20% and this figure is subtracted from the total gross income.

The standard deduction is subtracted from the income amount.

The monthly dependent care deduction up to the maximum amount is subtracted from the remaining income.

The allowable shelter expenses are added to determine total shelter costs. 50% of the adjusted income (the AG's monthly income after all the above deductions have been subtracted) is subtracted from the total shelter costs. The remaining amount, if any, is the excess shelter deduction.

- If there is no excess shelter deduction, the net monthly income has been determined.

- If there is excess shelter deduction, the excess shelter deduction is subtracted up to the maximum amount allowed.

The AG's net income is determined.

NOTE: It is possible that certain AGs may meet the gross income eligibility determination, but not be eligible for any benefits due to excess net income. This case shall be denied if at application or cancelled if a change has been reported.

3445.25.00 NET INCOME CALCULATION FOR ELDERLY/DISABLED AGS (F)

The following steps outline the determination of an AG's net income if the AG has at least one member age 60 or over or who is disabled. For determination of eligibility and benefit levels for all other AGs, refer to the Gross Income Eligibility Determination Section.

The total nonexcluded gross income of all members of the AG is added to the income of disqualified members (see Budgeting AGs with Disqualified Members, Section 3445.55.00). This figure will include both earned and unearned income.

The total gross earned income is multiplied by 20% and this figure is subtracted from the total gross income.

The standard deduction is subtracted from the income amount.

$35 is subtracted from the verified nonreimbursable medical expenses.

The monthly dependent care expense up to the maximum amount is subtracted from the remaining income.

The allowable shelter expenses are added to determine total shelter costs. 50% of the adjusted income (the AG's monthly income after all of the above deductions have been subtracted) is subtracted from the total shelter costs. The remaining amount, if any, is the excess shelter cost.

- If there is no excess shelter cost, the net monthly income has been determined.

- If there is excess shelter cost, the excess shelter cost is subtracted from the AG's monthly income after all the above deductions have been made.

The AG's net Food Stamp income is determined.

3445.30.00 165% INCOME LIMIT BENEFIT CALCULATION (F)

When an individual is 60 years of age or older and resides with others but is unable to purchase and prepare meals, he may be able to be a separate AG if the following conditions apply:

- he suffers from a disability considered permanent by the Social Security Administration (SSA) or suffers from a non-disease-related, severe, permanent disability, and

- the gross income of the others with whom he resides (excluding the income of the individual's spouse) is less than the 165% Gross Income Limit (found in Chapter 3000).

The information to support the requirement is entered on AEIDP.

If eligible, the individual's spouse (and dependent children) must also be included in the AG.

ICES will determine eligibility for this provision by including all those who eat together and their income. If the AG passes the 165% gross standard it will fail the AG with all included with reason code 359 and then form separate AG's with the elderly disabled individual (their spouse and their dependent children) in a separate AG.

3445.35.00 ROUNDING (F)

In calculating net Food Stamp income, cents are retained in all calculations made to determine the Food Stamp income. The final income figure is rounded to the closest dollar amount. The amount is rounded down if the income figure ends in one cent through 49 cents, and rounded up if the income figure ends in 50 cents through 99 cents.

3445.40.00 FOOD STAMP BENEFIT LEVEL (F)

The net monthly income is compared to the net income eligibility standards for the appropriate AG's size. If the AG is determined eligible, ICES will determine benefit levels. ICES will prorate benefits if the AG is subject to prorated benefits.

All one and two person AGs which pass the net income test are entitled to a minimum $10 allotment. However; If the initial month's benefits for one and two person AGs are prorated to less than $10 the AGs are not entitled to an allotment. NOTE: There are times when other AG sizes may receive less than $10 per month. Refer to the allotment tables.

If the net income exceeds the limit the AG is denied benefits except for categorically eligible assistance groups. Categorically eligible AGs of one or two persons will receive at least the minimum benefit of $10 unless it is prorated. Categorically eligible AGs with zero allotments will be suspended.

3445.40.05 Prorating Benefits (F)

An AG's allotment for the initial month of entitlement is based on the day of the month it applies for benefits. AGs

receive allotments prorated from the day of application to the end of the month. (f25)

An exception to the above occurs with migrant and seasonal farm workers. These AGS do not have their allotment prorated. They receive a full month's allotment for the initial month of participation if the AG has participated in the Food Stamp program in any state within 30 days prior to the date of application.

At application, AGs which provide untimely verifications (after the 30th day) will not receive benefits for the month in which the application was filed if the household was at fault for the delay. (f25a)

ICES calculates the prorated allotment, provided verifications are input into ICES on the day they are received. However, if the proration must be completed off-line the following formula may be used:

$$\text{FULL MONTH'S BENEFITS} \times \frac{\text{(NUMBER OF DAYS IN MONTH MINUS THE DATE OF APP + 1)}}{\text{NUMBER OF DAYS IN MONTH}} = \text{ALLOTMENT}$$

EXAMPLE:

THE DATE OF APPLICATION IS 5/20 AND THE FULL MONTH ALLOTMENT FOR THE AG IS $218.

1. NUMBER OF DAYS IN MAY IS 31 MINUS THE DATE OF APP (20) =11 PLUS 1 =12.
2. 218 MULTIPLIED BY .387 (12/31, FROM THE CALCULATION IN #1 ABOVE). THE PRORATED BENEFIT IS $84 (CENTS ARE DROPPED).

218.00 DIVIDED BY 31 (NUMBER OF DAYS IN MONTH) X 12 EQUALS PRORATED BENEFIT OF $84.00 (CENTS ARE DROPPED.)

To figure the 2nd month proration, the worker will enter the date the final verification(s) came in by entering this date on AEFPY in the field 'prorate date'. The system will automatically prorate the 2nd month's benefits from this date.

3445.50.00 BUDGETING AGs WITH DISQUALIFIED MEMBERS (F)

Individual AG members may be disqualified for:

- IPV;
- failure to obtain or refusal to provide an SSN;
- failure to comply with a work requirement;
- ineligibility as an alien;
- failure to comply with ABAWD (Able Bodied Adults Without Dependents) requirements.

- fleeing to avoid prosecution, custody or confinement after conviction.
- violating a condition of federal or state probation or parole
- felony conviction under state or federal law for an offense related to the possession, use or distribution of a controlled substance.

During the period of time an AG member is disqualified, the following procedures are used to determine the eligibility and benefit level of any remaining AG members. (f26) ICES determines the amounts of resources, income and expenses of disqualified members automatically.

The entire amount of income and expenses of an AG member disqualified for IPV, Work Registration, IMPACT, ABAWD non-compliance, fleeing felon, parole/probation violation or felony drug conviction is considered in the eligibility and benefit calculation.

A prorata share of the income and expenses of the SSN ineligible member or ineligible alien disqualified member is counted as income to the remaining members. This prorata share is calculated by first subtracting the allowable exclusions from the disqualified member's income and dividing the income evenly among the AG members, including the disqualified member. All but the disqualified members' share is counted as income to the remaining AG members. The 20% earned income deduction applies to the prorata income.

An ineligible individual(s) is not considered when determining the AG's gross/net income limits or allotment level. ICES determines the prorated income and determines the eligibility/allotment.

The resources of all disqualified members are considered in their entirety along with the resources of eligible members to determine eligibility.

The resources and income of the sponsor and the sponsor's spouse are not included in determining the resources and income of an ineligible sponsored alien.

3445.55.00 BENEFIT CALCULATION WITH INCOME FROM SPONSOR (F)

If an alien is sponsored by an individual rather than an organization, a portion of the sponsor' income is considered to be available to meet the needs of the alien.

The monthly income considered available to the alien from the sponsor (and the sponsor's spouse) is determined according to the following standard:

Sponsor + Spouse's Total Gross Earned Income	=	$ _____
Earned Income Deduction		- __(20%)
Countable Earned Income	=	_____
Sponsor + Spouse's Total Unearned Income	=	_____
Total of Countable Earned and Unearned Income	=	+ _____
Gross Income Limit for Sponsor's Household Size (Sponsor, Sponsor's Spouse and Tax Dependents)		- _____
Total Unearned Deemed Income from Sponsor		$ _____

NOTE: Total deemed income from sponsor is divided by the number of this sponsor's sponsored aliens in Food Stamp recipient AGs and the result attributed to each AG. No changes in this attributed income are needed unless/until recertification, the alien's sponsor changes, or the sponsor dies. (f27)

3445.60.00 NO FS INCREASE WHEN TANF DECREASED DUE TO NON-COOPERATION (F)

Food Stamps will not be increased when failure to comply with public assistance programs requirements results in a decrease of the public assistance payment for the AG. (f27a)

At this time only SSI and TANF benefits fall under this definition.

This rule only applies to Assistance Groups (AG) that are authorized to receive benefits at a reduced level due to non-cooperation with TANF or SSI as determined by these programs. This policy will be applied when TANF clients are sanctioned or disqualified for IMPACT, IV-D, Intentional Program Violations and when fiscal penalties are applied to the TANF AG. It does not apply in situations where an AG does not meet program requirements. For example, reduced benefits due to the 24-month time limit, family cap, or new alien requirements would not be considered non-compliance.

If a TANF AG is approved with a fiscal penalty or an individual member is sanctioned for any month, the FS benefits for the AG will be calculated with the full TANF amount before the sanction or fiscal penalty is deducted. ICES-EDBC will have to recalculate the TANF grant without the fiscal penalty and /or sanction and use this amount in the FS budget to ensure there is no increase in FS as a result of the TANF reduction.

It will apply whenever a IV-D, IMPACT or Voluntary Quit Sanction or Fiscal Penalty is authorized for TANF and the AG is receiving FS.

This policy only applies when the individual is receiving Food Stamps or was an ineligible Food Stamp member at the time of the penalty for failure to comply with the requirement for TANF or SSI is authorized.

Because TANF sanctions and Fiscal penalties by themselves do not terminate TANF eligibility for the AG, this policy will not apply when a TANF case is closed and a sanction or penalty is in effect and the Food Stamp case remains open. For example a TANF case with an IMPACT sanctioned member is closed due to earnings effective 3-1-1999. The TANF award will be removed from the FS budget for 3-1-1999. Should the client reapply at a later time and the TANF sanction is continued when the case is reopened, the FS budget should reflect what the new TANF award would be without the sanction.

The policy will not be applied when the act of non-compliance results in a "Dual" FS sanction as well as a TANF or SSI sanction. For example, a person exempt from FS work registration because they are referred to the TANF work program will be sanctioned/disqualified by both programs resulting in decreased benefits for both programs. In this situation benefits will be reduced for both programs when the person is disqualified. For example, an individual who receives a penalty in both TANF and Food Stamps for Voluntary Quit will have the actual TANF amount after the penalty is applied budgeted for Food Stamps.

As options under PRWORA are taken to extend all TANF disqualifications to the FS Program the application of this policy may be limited to situations where "fiscal sanctions" are applied to TANF recipients who retain eligibility for both programs.

If information about SSI sanctions is not available to the State Agency, the State agency will not be penalized by QC for increasing FS benefits.

Occasionally, the Food and Consumer Service has provided lists of SSI recipients who were overpaid SSI benefits due to a fraudulent act as determined by an SSA hearing. These lists have never included a current Indiana resident, however; if you suspect an SSI recipient's benefit has been reduced due to fraud you must contact the Social Security Administration to attempt to verify the reason for the reduction. If the SSI payment is reduced due to a fraudulent act, we must budget the SSI amount prior to the reduction to ensure "no FS increase".

TANF recoupments to collect overissued benefits that resulted from an IPV will not be deducted from the FS budget. This amount may be in addition to the reduction of benefits due to the disqualification of an individual. ICES will continue to include any recoupment of TANF benefits to repay a TANF IPV overissuance in the FS budget. This policy has been in effect for many years but was not applied because TANF did not determine if overissuances were the result of an IPV. (f27b)

If it is later determined that the reduction of TANF was not appropriate, the reduction in the Food Stamp benefits must be restored.

3450.00.00 FINANCIAL ELIGIBILITY & BENEFIT CALCULATION(C)

After the AG members have been determined in accordance with Chapter 3200.00.00 and the need standard established as directed in the following section, a determination of the assistance group's financial eligibility is made. The Cash Assistance financial eligibility determination is a comparison of the AG's needs to the AG's countable income.

Budgeting procedures are discussed in the following sections.

3450.05.00 CASH ASSISTANCE NEED STANDARD (C)

The need standard is the maximum expense consideration allowed to any Cash AG in the determination of financial eligibility. The need standard includes consideration for expenses of daily living such as rent, utilities, food, clothing, and personal needs. Indiana's need standard is a flat maintenance allowance which varies by AG participation member size and composition.

Indiana's consolidated need standard assumes that all people have expenses without the justification or verification of those expenses. It further assumes that greater need exists for AGs which include a parent/caretaker than for those compared solely of dependent children.

3450.05.05 185% Gross Income Test (C)

The following applies to TANF applicants, and Refugee Cash Assistance applicants.

To be financially eligible, the AG's total nonexempt gross income (including deemed income in accordance with Section 3450.45.00) cannot exceed the AG's total need times 185%. If allocation from a parent's income is required, allocation is discussed in Section 3450.40.05. To determine eligibility under this provision:

Multiply the total need standard of the AG by 1.85 and compare the resulting figure to the total of earned, unearned, and deemed income.

If the income exceeds the needs in this calculation, the AG is ineligible for a Cash assistance benefit. (f28)

If the income does not exceed the needs, further calculations are required to determine the AG's benefit amount.

3450.10.00 CASH ASSISTANCE RATEABLE REDUCTION (C)

The rateable reduction is a cost containment calculation that requires the need standard to be reduced prior to benefit calculation. The need standard is multiplied by .90 which reduces the needs by 10% to arrive at an adjusted needs total. (f29)

3450.15.00 EARNED INCOME DEDUCTIONS (C, MED 2, MED 3)

Certain deductions are allowed in determining the amount of countable earned income for the purposes of financial eligibility and Cash Assistance benefit calculation. These earned income deductions are discussed in the following sections.

3450.20.00 WORK EXPENSE DISREGARD (C, MED 2, MED 3)

A monthly work expense disregard is allowed from gross earned income as follows:

A work expense disregard of $90 is allowed as a deduction per participating AG member. A sanctioned nonparticipating AG member also receives this deduction.

A work expense disregard of $90 is allowed as a deduction per nonparticipating AG member. For example, a nonparticipating member may be a parent of a minor pregnant applicant/recipient or a spouse of an applicant/recipient.

3450.25.00 $30 AND 1/3 DISREGARD (C, MED 2)

The policy stated in this section applies to MA C and all categories of cash assistance.

In addition to the work expense disregard, a work incentive disregard of $30 and 1/3 is applied to the remaining earned income of participating AG members and mandatory members who are not participating because of a sanction. This disregard is applied for four consecutive months.

NOTE: an individual may have two different $30 and 1/3 disregard periods at the same time: one for TANF (or RCA) and one for MA C.

The following sections discuss when this incentive deduction may be applied.

3450.25.05 $30 And 1/3 Disregard At Initial Eligibility (C, MED 2)

The policy stated in this section applies to MA C and all categories of cash assistance.

When determining initial eligibility, the $30 and 1/3 disregard is applied if the AG's gross income minus deductions for the $90 work expense disregards and allowable child care costs results in a net income figure which is less than the AG's total adjusted needs.

For TANF (or RCA), the earliest the disregard can be applied is for the first payment month. For MA C, the disregard could begin in the retro period.

Once the $30 and 1/3 disregard has been applied to an individual's income, subsequent entitlement to the disregard is determined as explained in Section 3450.25.15.

REMEMBER: there are two different $30 and 1/3 disregards (one of TANF {or RCA} and one for MA C) and as such a family receiving MA C and TANF (or RCA) may have two different $30 and 1/3 periods.

3450.25.10 $30 And 1/3 Disregard At Reapplication (C, MED 2)

The policy stated in this section applies to MA C and all categories of cash assistance.

When determining eligibility at reapplication for TANF (or RCA), the $30 and 1/3 disregard is deducted from the income of any individual who is a member of a TANF (or RCA) or MA C unit:

which received assistance in one of the preceding four months (must have previous TANF for TANF disregard, RCA for the RCA disregard and MA C for MA C disregard); or

whose AG's gross income minus deductions for the $90 work expense disregard and allowable child care costs results in a net income figure which is less than the TANF (or RCA) AG's total adjusted needs; and

had not previously had the $30 and 1/3 deduction applied against his earnings for four consecutive months, or has had the four consecutive months of $30 and 1/3 deduction, but has been off assistance for a period of 12 consecutive months after receiving the disregard.

3450.25.15 $30 And 1/3 Disregard For Ongoing Cases (C, MED 2)

The policy stated in this section applies to MA C and all categories of cash assistance.

When determining ongoing eligibility, the $30 and 1/3 disregard is deducted if:

the AG received assistance in one of the preceding four months (must have previous TANF for TANF disregard, previous RCA for the RCA disregard and previous MA C for MA C disregard); and

the AG member with earnings had not previously received four consecutive months of the disregard, or had received four consecutive months of the disregard, but has been off of assistance for a period of 12 consecutive months after receiving four months of $30 and 1/3 disregard.

3450.25.20 Determining Countable Months Of $30 And 1/3 Disregard (C, MED 2)

The policy stated in this section applies to MA C and all categories of cash assistance.

The $30 and 1/3 disregard is applied to earned income for four consecutive months. In determining the months, the following guidelines apply:

If any part of the $30 and 1/3 disregard is applied (even less than $30), a month of $30 and 1/3 is counted.

When receipt of the $30 and 1/3 disregard is interrupted before the expiration of four consecutive months, the four consecutive month period begins over when the first month disregards are again applied.

Any month in which an individual does not receive the $30 and 1/3 disregard due to the penalties set forth in Section 3450.30.00 is to be counted toward the four consecutive months limitation.(f30)

Overpayment calculations involving the $30 and 1/3 disregard count as a month of disregard. These calculations may change a previously calculated expiration of $30 and 1/3.

3450.25.25 $30 Disregard (C, MED 2)

The policy stated in this section applies to MA C and all categories of cash assistance.

Upon expiration of the $30 and 1/3 disregard, an applicant/recipient is entitled to a deduction of $30 from

the earned income remaining after the standard work expense disregard is subtracted. The entitlement to the $30 disregard is limited to a period of eight consecutive months (with regard to ADCQ, until the end of their eight (8) month period) and begins the month following the month the $30 and 1/3 disregard expired.

This period continues for eight calendar months regardless of whether or not the $30 disregard is utilized.

If an individual becomes ineligible for TANF or MA C after receiving the $30 and 1/3 disregard for four consecutive months, but before the eight additional months of the $30 disregard expires, the individual is eligible for the remaining months of the $30 disregard if he returns to apply for TANF or MA C during that time.

This deduction is allowed for participating AG members and nonparticipating sanctioned AG members.

3450.30.00 (RESERVED)

3450.35.00 (RESERVED)

3450.35.05 Benefit Calculation (C)

If allocation from a parent is required, the calculations discussed in Section 3450.40.10 are used.

To determine benefit entitlement for Cash Assistance (after allocation from a parent if required):

Determine the total need standard of the participating AG members;

Ratably reduce (multiply) total needs by .90, resulting in the adjusted need amount;

Determine the amount of non-exempt gross earned, unearned, and deemed income;

Subtract applicable earned income deductions from gross income, including:

- work expense disregard,
- $30 and 1/3 disregard, and
- incapacitated adult care expenses.

The result is the net countable income. If the countable income is equal to or exceeds 100% of the Federal Poverty

Guidelines (FPG) for the assistance group size the family is ineligible for cash assistance.

Conversely, if net countable income is less than 100% of the Federal Poverty Guidelines, the family is eligible for cash assistance. Once the assistance group is determined eligible under the 100% FPG test, benefits are determined by disregarding 75% of the gross income and applying 25%. The maximum benefit amounts are listed at 3050.10.00.

An on-going AG's countable income must be less than 100% of the Federal Poverty Guideline **to be** eligible for cash assistance. (f33a)

3450.40.00 ALLOCATION OF PARENTS' INCOME (C, MED 2)

Allocation is the process of allowing a participating AG parent's income to be used to meet the needs of certain nonparticipating AG members prior to the consideration of the income in the benefit calculation. A parent's income may be allocated to meet the need standard of a nonparticipating spouse and the participating parent's nonrecipient dependent child(ren). Income is never allocated to stepchildren, SSI recipients, or sanctioned individuals.

Allocation to a spouse occurs only when the spouse does not have sufficient income to meet his needs. Allocation to a child under age 18 always occurs regardless of the child's income.

Budgeting procedures are discussed in the following sections.

3450.40.05 Allocation/185% Test (C, MED 2)

To determine the amount of income to be counted in the 185% test when allocating income from a parent:

Determine the amount of the parent's gross income;

Subtract an amount equal to the unmet needs of the nonparticipating children and spouse by:

- determining the nonparticipating spouse's gross income;
- subtracting the work expense disregard;
- subtracting the total need standard of nonparticipating children in the home who are solely the spouse's responsibility;

- subtracting the total need standard of the nonparticipating spouse and common children;

  If the spouse has insufficient income to meet the needs of children who are solely his responsibility, the allocation equals the need standard of the nonparticipating spouse and children.

The remainder of the parent's income, if any, is counted in the 185% test.

3450.40.10 Allocation/Benefit Calculation (C)

To determine eligibility and the benefit amount when allocating income from a parent:

Determine the amount of the parent's gross income;

Subtract applicable earned income deductions including:

- work expense disregard;
- $30 and 1/3 disregard; and
- incapacitated adult care expense;

Subtract an amount equal to the unmet needs of the nonparticipating common children under age 18 and spouse by:

- Determining the nonparticipating spouse's gross income;

- Subtracting the work expense disregard from earned income;

- Subtracting the total need standard of nonparticipating children in the home under age 18 who are solely the spouse's responsibility;

- Subtracting the total need standard of the nonparticipating spouse and common children under age 18.

If the spouse has insufficient income to meet the needs of children who are solely his responsibility, the allocation equals the need standard of the nonparticipating spouse and common children.

The remainder of the parent's income, if any, is counted in the benefit calculation and amount as described in sections 3450.35.00 and 3450.35.05.

3450.45.00 DEEMED INCOME CALCULATION (C)

Deeming is the process of counting a portion of the income of certain nonparticipating AG members in the Cash Assistance benefit calculation. The income of the following persons is deemed available to the participating members of the AG:

- Sanctioned parents (Section 3450.45.10.00);
- Ineligible parents (Section 3450.45.10.05);
- Stepparents (Section 3450.45.05);
- Spouses of non-parental caretaker relatives who are participating members of the AG (Section 3450.45.05);
- Parents of minor parents living in the home (Section 3450.45.15); and
- Sponsors of aliens (Section 3450.45.35).

Prior to deeming, a portion of the income of these nonparticipating members is used to meet the need standard of themselves and a nonparticipating spouse or children under age 18. Children may be solely the responsibility of the nonparticipating parent (he is the only parent in the home) or common children (nonparticipating children with both parents in the home).

The deeming calculation is discussed in the following sections.

3450.45.05 Income Deemed From A Stepparent/Non-Recipient Spouse (C)

The non-exempt income of a stepparent living in the home or that of a non-parent caretaker relative's spouse (provided that the caretaker has opted to be included on the grant) is first considered to meet the needs of the stepparent/spouse and his dependents.

The needs of a sanctioned individual or an SSI recipient are not included when determining the amount of the stepparent's or spouse's income necessary to meet his and his dependents' needs.

When determining the amount to be deemed to the TANF AG from the stepparent, the Local Office is to:

Determine the amount of the stepparent or spouse's gross income (to determine gross income from self-employment, see Section 3410.00.00);

Subtract the $90 work expense disregard from earned income. Subtract mandatory deductions actually being withheld from unearned income; (f34)

Subtract an amount equal to the need standard of the stepparent's or spouse's dependent children living in the home (children only standard);

Subtract an amount equal to the need standard of the stepparent/spouse and any dependent children common to the stepparent/spouse and his applicant/recipient spouse;

Subtract the actual amount paid to dependents living outside the home (a dependent is any person who is or could be claimed by the stepparent for tax purposes);

Subtract the actual amount of child support or alimony paid to persons living outside the home regardless of whether or not they are or could be claimed for tax purposes; and

The remaining income is to be counted in all eligibility determinations for the TANF AG. (f35)

When the above determination includes the needs of the ineligible parent of an TANF child, any countable income that the parent has in his own right, either earned or unearned, is to be taken into account in determining the eligibility of the TANF AG.

3450.45.10 Income Deemed From A Sanctioned Individual (C)

When the sanctioned individual is a parent or sibling of a TANF eligible child who is required to be included in the standard filing unit, the income of the sanctioned person is to be budgeted as deemed income to determine the financial eligibility and assistance payment for the remaining AG members. (f36)

The sanctioned person is not allowed the following income considerations:

A deduction from his income to meet his needs or the needs of any nonrecipient dependent for whom he is responsible;

The disregard of earned income extended to a TANF child who is a full-time or part-time student; and

The disregard of JTPA earned income extended to a TANF child.

In determining the amount of income deemed available to the TANF AG from the sanctioned person, the Local Office is to allow the following income disregards: (f37)

the $90 work expense disregard;

the $30 plus 1/3 and $30 disregards;

the child/incapacitated adult care disregard.

3450.45.10.05 Income Deemed From An Ineligible Parent (C)

Persons serving under a lump sum period of ineligibility, aliens who do not meet the citizenship or alienage requirements, and aliens with sponsors whose income and resources are sufficient to meet the needs of the alien are specifically precluded from receiving TANF benefits. When this ineligible person is a parent of a TANF child, the ineligible parent's income is to be considered in determining the financial eligibility of his child applying for or receiving assistance. In determining the amount of income deemed available to the TANF AG from the ineligible parent, the Local Office is to: (f38)

Determine the parent's countable income (the parent is allowed only the $90 work expense disregard against his earnings); (f39)

Subtract from the parent's countable income the need standard of the ineligible parent and his nonrecipient dependents who live with him. These dependents include only the parent's non-eligible natural or adoptive children under age 18 and the parent's spouse without income or with income which is insufficient to meet his needs. However, the needs of a spouse or a child who receives SSI are not considered in this determination.

When the ineligible parent's spouse has income, but the spouse's income is insufficient to meet the need standard of his dependents and himself, an additional computation is necessary. The purpose of this computation is to determine the amount of the allocation necessary from the parent's income to meet the deficit between the spouse's and his dependent's needs and the spouse's income, following the budgeting procedures established in Section 3420.10.20.

The ineligible parent's remaining income is deemed available to the TANF AG (budgeted in the 185% test) and is considered in the eligibility determination of Treatment AG's and in the eligibility determination and benefit calculation of Control Group AG's.

3450.45.15 Income Deemed From The Parent(s) Of A Minor Parent (C)

The non-exempt earned and unearned income of a nonrecipient parent of the minor parent who is living in the home is deemed available to the minor's TANF AG.

Income is deemed from the nonrecipient parent of a minor parent even when the minor parent is married as long as the parent and his spouse reside with the parent.

There is no income allocated to meet the needs of SSI recipients or sanctioned individuals.

3450.45.20 Income Deemed From Two Non-Recipient Parents (C)

When determining the amount to be deemed to the TANF AG, the Local Office is to:

Determine the amount of each parent's gross income (see Section 3410.00.00 for determination of gross self-employment income);

Subtract the $90 work expense disregard from earned income. Subtract any mandatory deductions actually being withheld from unearned income;

Subtract an amount equal to the need standard of any non-common dependent children from each parent's income;

Subtract from each parent's income the actual amounts paid for dependent(s) living outside the home, child support or alimony;

Add the net incomes of the two parents together;

Subtract an amount equal to the need standard of the two parents and their dependent children in common;

Remainder is income to the TANF AG.

3450.45.25 Income Deemed From Non-Recipient Parent With Spouse (C)

When determining the amount to be deemed to the TANF AG, the Local Office is to:

Determine the amount of the parent's gross income (see Section 3410.00.00 for determination of gross self-employment income);

Subtract the $90 work expense disregard from earned income. Subtract any mandatory deductions actually being withheld from unearned income;

Subtract an amount equal to the need standard of the parent and the parent's dependent child under 18 years of age living in the home who is solely the parent's responsibility;

Subtract from the parent's income the actual amount paid for a dependent living outside the home, child support or alimony;

Determine the spouse's available income by using the same procedures as the stepparent deeming procedures to determine what are the needs. Deduct an amount equal to the verified unmet needs of the spouse and any common children. (If the spouse refuses to provide verification of income no allocation can be made to the spouse or common children.)

Remainder is income to the TANF AG.

3450.45.30 Income Deemed From A Non-Recipient Parent With No Spouse (C)

When determining the amount to be deemed to the TANF AG, the Local Office is to:

Determine the amount of the parent's gross income (see Section 3410.00.00 for determination of gross self-employment income);

Subtract the $90 work expense disregard from earned income. Subtract any mandatory deductions actually being withheld from unearned income;

Subtract from the parent's income the actual amount paid for a dependent living outside the home, support payments or alimony;

Subtract an amount equal to the need standard of the parent and any dependent child under the age of 18 years living in the home;

Remainder is income to the TANF AG.

3450.45.35 Income Deemed From An Alien's Sponsor (C)

The policy stated in this section does not apply to the ADCR and ADCQ categories of assistance.

The income of an individual sponsoring an alien is considered in determining the alien's eligibility for TANF.

To determine monthly income deemed available to the alien from the sponsor (and the sponsor's spouse if living with the sponsor) not receiving TANF or SSI:

Total the earned and unearned gross income of the sponsor and the sponsor's spouse;

Subtract 20% of the earned income amount not to exceed $175;

Subtract the total need standard of the sponsor and other individuals living in the sponsor's home who are claimed by the sponsor as dependents to determine his federal personal income tax liability. Do not include individuals who receive TANF or SSI.

Subtract support payments made by the sponsor or spouse, including:

- spousal or child support to individuals outside the home; and

- amounts paid by the sponsor to individuals outside the home who are claimed by the sponsor as dependents to determine his federal personal income tax liability;(f41)

The remainder of the income, if any, is counted in the 185% test and benefit calculation.

When an individual is a sponsor of two or more aliens living in the same home, the sponsor's deemed income is equally divided among the aliens. (f42)

3450.50.00 INCOME OF THE MINOR PARENT (C)

There are no minimum or maximum age limitations required of otherwise eligible TANF recipients. A minor under age 18 may be eligible to receive assistance for himself as well as for his dependent child.

When the child of a minor parent is added to an existing TANF AG, the income of the minor parent who is also an eligible child in the grant of his parent or caretaker is to be treated in the same manner as that of any other child. The income is to be given the same consideration with respect to disregards, exemptions, and so forth.

When the minor parent is considered in the AG as the parent or caretaker and the minor aged parent has no applicant/recipient siblings which would force the minor parent to take a dependent child role within the AG, only the income which is available to the minor parent is to be budgeted in all eligibility determinations. The income is

to be given the same consideration with respect to disregards, exemptions, and so forth as that of any other caretaker relative applicant or recipient.

Any income that is drawn for the direct benefit of a minor parent is considered to be available in total when such benefit is made payable to the minor or to a representative payee who lives with the AG.

3450.55.00 PRORATING BENEFITS (C)

Cash benefits are prorated when an application is filed on the first day of any month containing 31 days. When this occurs, a one day benefit is payable for that month. Proration does not occur in any other situation.

3450.60.00 (RESERVED)

3455.00.00 BENEFIT CALCULATION (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

Eligibility for MA with regard to income is based on the countable income of the individual and his financially responsible relatives. Situations in which income is deemed from parents and spouses are identified in the following sections.

The budgeting process consists of two steps: eligibility and post-eligibility. The eligibility step is completed for every AG. Refer to Section 3455.05.00. For individuals in long term care (LTC), the post-eligibility step is also completed to determine the patient liability if the AG has passed the eligibility step. Refer to Section 3455.15.00. More detailed information regarding the circumstances which require a particular budgeting procedure pertaining to situations involving an institutionalized applicant/recipient with a community spouse can be found in Sections 3455.05.05, 3455.15.10, 3455.15.10.10, and 3455.15.10.15. Refer to Section 2635.10.10 for eligibility information regarding an institutionalized applicant/recipient with a community spouse.

3455.05.00 ELIGIBILITY BUDGETING (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

In the eligibility budgeting procedure, the total non-exempt unearned and earned income, less allowable deductions, is compared to the appropriate income standard in Chapter 3000.

If the resulting amount is equal to or less than the appropriate income standard, the individual is financially eligible. The individual with income in excess of the income standard will pass financial eligibility only if allowable incurred medical expenses exceed the surplus income.

The eligibility budget is displayed on screen AEBMB.

3455.05.05 Budgeting Income Of Applicant/Recipient And Spouse (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

The non-exempt income of the applicant/recipient and the non-exempt income of his spouse who is not receiving TANF are counted together in the eligibility budget computation. This does not apply when one spouse is in a long term care (LTC) facility; the spouses are budgeted separately in that instance.

When an applicant/recipient has stepchildren living in the home, his spouse's income must first be allocated to meet the needs of the spouse's own biological or adoptive dependent children who are under age 18 or students between age 18 and 21 who are not receiving TANF and who are living with the couple. The amount to be allocated is the income standard minus the child's non-exempt income. The spouse's remaining income is then combined with the applicant's/recipient's income in the budget computation. Income is not allocated from the income of the applicant/recipient to stepchildren. (f45)

The eligibility budget is displayed on screen AEBMB.

3455.05.05.05 Disregard Of RSDI 20% COLA In October 1972 (MED 1)

The policy stated in this section only applies to the MA A, MA B, and MA D categories of assistance.

The amount of the 20% increase in Social Security benefits received in October 1972 under Public Law 92-336 is disregarded if, for the month of August 1972, the non-institutionalized applicant/recipient was a recipient of Old Age Assistance, Blind Assistance, or Disabled Assistance. (f46)

3455.05.05.10 Disregard Of RSDI COLA In Transition Months (MED 4)

The Cost of Living Adjustment (COLA) received annually in January by Social Security beneficiaries is disregarded

until April of the same year. (f47) This results in the RSDI benefit increase coinciding with the income standard increase which occurs when the new Federal Poverty Guidelines are published. The months of the COLA disregard are referred to as "transition months".

NOTE: The April 1 date is based on the assumption that the Federal Poverty Guidelines are published as usual in February. If, in any given year the poverty guidelines are published in a month other than February, Local Offices will be notified of the transition months.

3455.05.05.15 Plan For Achieving Self-Support (PASS) (MED 1, 4)

The policies explained in this section apply only to the MA B, MA G, MA L, MA J, MA I, and MA K categories of assistance.

There are two kinds of Plans for Achieving Self-Support (PASS). One is an SSI PASS which is approved by the Social Security Administration for SSI eligibility purposes. The other is a Medicaid PASS which is approved by the Division of Family and Children, Central Office, for Medicaid eligibility purposes.

A PASS can be developed for an individual who needs to set aside a part of his income for a specified period of time necessary to achieve an occupational objective. The income could be used for current expenditures or saved for a later planned expenditure to achieve a work-related goal such as education, vocational training, starting a business, or purchasing work-related equipment.

For individuals in the MA B category (SSI recipients and non-SSI recipients) as well as non-SSI recipients in the MA L, MA G, MA J, MA I, and MA K categories, a PASS must be approved by the Central Office of the Division of Family and Children. (f48) In order for a PASS to be approved, the Local Office must submit a letter to the Central Office containing:

the description and objectives of the plan as discussed with the applicant/recipient;

the source and amount of all income and resources and what amounts of each are to be used in the plan;

the length of time the plan is to operate; and

any other pertinent information including documentation from the Social Security Administration of an SSI recipient's approved PASS.

This letter is to be prepared in triplicate, with two copies sent to the Central Office, Family Independence Section, Medicaid Eligibility Unit, and one retained in the case record. The Central Office will forward a copy to the Blind and Visually Impaired Section of the Division of Aging and Rehabilitative Services for their recommendation. The Central Office will then review the self-support plan and recommendation from the Blind and Visually Impaired Section of the Division of Aging and Rehabilitative Services, and notify the Local Office by letter of approval or disapproval. The Local Office will then notify the applicant/recipient. If the plan is approved, the amount of income and resources disregarded and time period for the disregard must be documented in the case record. A Medicaid approved PASS is coded in ICES as PM.

In the QMB, QDW, SLMB, and QI eligibility determinations of SSI recipients who have a PASS approved by the Social Security Administration, a separate approval from the Central Office is not required. A copy of SSA's documentation should be obtained and filed in the case record. An SSI PASS is coded in ICES as PS.

A PASS under the MA B category can be approved for a period not to exceed 12 months. For MA L, MA G, MA J, MA I, and MA K, the PASS exemption will be for at least 18 months and may be extended up to 36 months.

3455.05.05.20 Darling v. Bowen Special Income Disregard (MED 1)

A special income disregard must be allowed for certain widow(er)s who are receiving RSDI benefits. This disregard is the result of an order issued by the U.S. District Court in the case of Darling v. Bowen. A list of the individuals who were entitled to consideration under Darling v. Bowen was sent to the Local offices on February 23, 1990. The disregard would have previously been applied to the affected individuals and is to be continued indefinitely. The disregard consists of the difference between the amount of the individual's RSDI benefit and the current SSI maximum benefit. It is entered on screen AEFUD as an unearned income deduction. If the individual has entered an institution, the special income disregard does not apply.

3455.05.10 Allocation To Dependent Child (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

An allocation is made to a dependent child living with the applicant/recipient if the child's income is less than the applicable income standard in Section 3010.20.05. A dependent child who has nonexempt income equal to or greater

than the income standard is not considered in the budget computation.

A dependent child is the applicant/recipient's biological or adoptive child who: (f49)

- is under age 18, or a student between age 18 and 21 who is regularly attending a school, college, university, or course in vocational or technical training designed to prepare him for gainful employment; and

- is not receiving TANF or Adoption Assistance.

The above definition is also applicable when allocating from the spouse of the applicant/recipient to the spouse's biological or adoptive child. On screen AEBMB, "eligible child" refers to one applying for or receiving MA under the blind or disabled category and "ineligible child" refers to one applying for or receiving MA under a category other than blind or disabled or who is not applying for or receiving MA.)

The amount to be allocated is the applicable income standard for the child minus the child's nonexempt income. (f50)

3455.05.15 Allocation To Essential Person (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

An essential person is a person other than the applicant's/recipient's spouse or parent who is considered by the applicant/recipient to be essential to his well-being because such person provides services to the applicant/recipient which would have to be paid for otherwise. (f51) If a spouse or parent is in the home and able to maintain the home and care for the individual, an essential person cannot be considered in the budget computation.

An allocation is made to an essential person if his nonexempt income is less than the income standard in Chapter 3000. (f52) Screen AEIHH gathers information that identifies essential persons when "E" is entered in field TD/EP.

3455.05.20 Parental Deemed Income (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

Income is deemed from the nonrecipient biological or adoptive parent's income when the applicant/recipient is: (f53)

living with the parent; and

under age 18 and not receiving Home and Community-Based Services under an approved Medicaid waiver.

When the applicant/recipient is a student between the ages of 18 and 21, the parents' income is not deemed. (Effective 1-1-2001)

When the applicant/recipient is institutionalized (including hospitalization), income is not deemed from the non-recipient biological or adoptive parents beginning in the month following the month of admission, or beginning in the month of birth if the child remains institutionalized/ hospitalized in the following month.

An allocation is deducted from the income of the parent to his spouse (the applicant's/recipient's stepparent) if the spouse has income of less than the income standard specified for a stepparent in Chapter 3000. The amount to be allocated is the income standard minus the stepparent's nonexempt income remaining after deducting an amount for the stepparent's child (step-sibling of the applicant/recipient) who has income of less than the income standard specified in Chapter 3000. An allocation is not deducted from the income of the applicant's/recipient's parent to the parent's stepchildren.

An allocation is deducted from the parent's income for a biological or adoptive nonrecipient child or child receiving MA under a category other than blind or disabled who:

is under age 18 or age 18 - 21 and a student;

is not receiving TANF or Adoption Assistance;

has income of less than the standard specified in Chapter 3000.

The amount to be allocated is the income standard minus the child's nonexempt income.

The general income disregard of $15.50 is deducted after allocations to dependent children, first from unearned income and then from earned. After the earned income disregards are applied to the parent's earned income, the countable unearned and earned income are totaled and compared to the applicable income standard in Chapter 3000. If the parent's income exceeds the income standard, the excess is deemed as income to the child applicant/recipient. If two or more children are applicants/recipients, a proportionate share of the parent's income is deemed to each. This budget is displayed on screen AEBMP.

3455.05.25 Eligibility Budgeting Procedures (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

The AG's financial eligibility is displayed on screen AEBMB and is determined by application of the following procedures:

The nonexempt unearned income of the applicant/recipient is determined first.

The amount of the applicant's/recipient's unearned income is added to the amount of the spouse's unearned income remaining after any allocation to a dependent biological or adoptive child of the spouse is subtracted, as explained in Section 3455.05.05.

If the applicant/recipient is a child, any income deemed from his parent, as explained in Section 3455.05.20, is added to his own income.

The general income disregard of $15.50 is subtracted. It is applied only once to a couple even when both members have income.

Allocations to dependent children of the applicant/recipient or to an essential person are then subtracted. The resulting amount is the countable unearned income of the applicant/recipient. If deductions are greater than the total unearned income, the remaining amount is deducted from any earned income.

Next, the total earned income (including self-employment) of the applicant/recipient (and spouse) is determined.

After subtracting any remaining allocations to a dependent child, the spouse's earned income is added to the earned income of the applicant/recipient.

Any remaining general income disregard is then subtracted.

Any remaining allocations to a dependent child or essential person are subtracted.

The earned income disregard of $65, plus impairment-related work expenses (IRWEs) as explained in Section 3455.07, plus one-half of the remaining income is subtracted. The resulting amount is the countable earned income.

The countable unearned income is then combined with the countable earned income and any amount under an approved Plan for Achieving Self-Support (PASS) for a blind applicant/recipient is deducted.

The applicable income standard (individual or couple) specified in Chapter 3000 is subtracted.

If there is no resulting surplus income, the AG is financially eligible for assistance.

If there is a surplus, the amount of allowable health insurance premiums is deducted.

If there is a resulting surplus income after an allowable health insurance premium is deducted, the AG is financially eligible if his other average monthly allowable medical expenses exceed his surplus income.

3455.06.00 ELIGIBILITY BUDGETING PROCEDURES FOR M.E.D. WORKS

This section applies to MADW and MADI.

The procedures for determining financial eligibility are as follows:

Income of the spouse is exempt in the eligibility determination. If the applicant/recipient is eligible, the spouse's gross income is then counted in the premium calculation.

a) Determine the countable unearned income of the applicant/recipient.

b) Subtract the general income disregard.

c) Determine the earned income of the applicant/recipient. This is the gross income from employment and self-employment after deducting allowable self-employment expenses.

d) Subtract any remaining amount of the general income disregard from earned income.

e) Subtract $65, any impairment-related work expenses as explained in Section 3455.07.00, and one half of the remainder.

f) Add the amount determined at steps b) and e) to arrive at total countable income.

g) If the countable income does not exceed the M.E.D. Works income standard specified in Section 3010.20.20, the individual is financially eligible. If the countable income is more than the standard, the individual is not eligible.

Procedures for calculating the premium are as follows:

Income of the applicant/recipient and spouse is considered for the premium calculation. All income types exempted in the eligibility determination are countable in the premium calculation except TANF benefits. The premium is calculated by adding the unearned income, gross employment income, net self-employment income (amount after allowable self-employment expenses), and net rental income.

The chart in Section 3010.20.20 is used to determine whether the income is sufficient to require a premium, and if it is, the premium amount. For a single applicant/recipient, the family size of 1 is used, and for the applicant/recipient living with a spouse, the family size of 2 is used. If both spouses are applying for or enrolled in M.E.D. Works, the premium amount for a family size of 2 according to the income is used, and the premium is a “couple premium”. This means that there is a single premium for the couple. This premium must be paid in order for both spouses to remain eligible.

3455.07.00 DEDUCTION OF IMPAIRMENT-RELATED WORK EXPENSES (MED 1)

The policy in this section applies to MA D, MADW, and MADI.

A deduction from the earnings of the applicant/recipient in the eligibility determination is allowed for Impairment-Related Work Expenses (IRWE) under the circumstances explained in this section. In order to be allowed as a deduction from earned income the IRWE must be paid by the applicant/recipient and related to the employment of the applicant/recipient. An expense which is merely incurred but not paid, is not allowable. An expense that has been, will be, or could be paid for by Medicaid, other insurance, or any other source including other state programs is not allowable.

Expense payments that are made less often than monthly are prorated. One time expenses are distributed over the redetermination period. Verification of payment of IRWEs is required. Additionally, if there is any question or inconsistency concerning the person’s need for a service which is being claimed as an IRWE, the caseworker can require verification of necessity from an individual knowledgeable of the situation.

Attendant care services.

Due to impairment(s), assistance is needed with personal functions in preparing at home to go to work, traveling to and from work, or while at work with personal or work-related functions. Payments made to a family member will be deducted only if the family member suffers economic loss by terminating employment or reducing hours of employment. (For this purpose, a family member is anyone, who is related to the applicant/recipient by blood, marriage, or adoption, whether or not the family member lives with the applicant/recipient.) Only the portion of the payment for attendant care services that is attributable to work-related expenses can be deducted. For example, an individual pays a personal attendant to help in preparing for work, doing light housekeeping, and assisting the individual in the evening with supper. The attendant works 8 hours a day, Monday through Friday, and 2 hours on Saturdays and Sundays. However, only 2 hours per day, Monday through Friday is spent on work-related assistance, that being the time in the morning preparing for work. Therefore, the allowable IRWE is the portion of the payment to the attendant for 2 hours of work per day, for 5 days a week.

Work-related equipment

Special equipment needed in order for the person to do his or her job. The equipment must be necessary due to the person’s impairment, and be something that the employer is not required to provide in accordance with federal law to accommodate the person’s disabilities.

Residential modifications

The type of home modifications that are allowable is determined by whether the person works away from home or in his home.

For employment away from home, allowable expenses are those made to the outside of the home that permit the person to access his or her means of transportation to and from work.

Costs for modifications inside the home are not allowable when the recipient works away from home.

For the person who works at home, costs can be allowed for modifying the home in order to create a working space to accommodate the person’s impairment. However, any cost deducted as a business expense on the self-employed person’s income taxes, cannot be allowed as an IRWE.

Transportation costs

Transportation costs are allowable IRWEs in the situations explained below. Transportation costs are not allowable for the routine cost of getting to and from work in situations where it is no relation to the person'' impairment.

Modification to a vehicle that is critical for the person’s use or operation and directly related to the person’s impairment, plus a mileage allowance in the amount allowed by the IRS. The cost of the vehicle is not allowable.

The person’s impairment requires the use of driver assistance, taxicabs or other hired vehicles in order to work. The cost of the transportation provide is allowed, or if the person’s own vehicle is used, a mileage allowance is permitted.

A mileage allowance is allowed if the person can’t use public transportation due to the impairment, and not due to unavailability of public transportation, and must drive his or her unmodified vehicle. The person’s inability to use public transportation must be verified by a physician.

Medical devices, prosthetics, drugs and other medical services are generally not allowable because Medicaid will pay for these items. Items paid for to meet spend-down cannot be used as IRWEs. For example, the spouse of a M.E.D Works member is on Medicaid Disability with a $200 spend-down. Non-Medicaid covered expenses of the spouse on M.E.D. Works can be used to meet the spend-down of the Medicaid Disability spouse, but only if that expense is not budgeted as an IRWE. Similarly, for spouse on Medicaid Disability, any expense budgeted as an IRWE cannot be used to meet spend-down.

3455.08.00 PREMIUM AND CATEGORY CHANGES IN M.E.D.WORKS (MED 1)

Premium Changes

When a M.E.D. Works recipient reports a change that imposes a premium or causes a decrease or an increase in the monthly premium amount, the new premium is to be effective in accordance with change processing rules in Sections 2200.05 and 2220.10. The imposition of a premium for a M.E.D. Works recipient and an increase in the premium are adverse actions requiring timely notice.

Category change to M.E.D. Works

When a Medicaid recipient in any other category becomes eligible for M.E.D. Works with a premium, it is an adverse action requiring timely notice. It is processed as an adverse action even if the recipient had a spend-down that was higher than the M.E.D. Works premium. The current category will be closed and the caseworker will conditionally approve M.E.D. Works. If the premium is lower than the spend-down, the caseworker must access CUMED and change the spend-down amount to the amount of the premium for the month following the month of authorization.

If a recipient in another category moves to M.E.D. Works with a premium prior to the adverse action date for the month, M.E.D. Works will begin the following month. Eligibility in the prior category will terminate as of the end of the month. Caseworkers should remind recipients of the importance of paying the premium immediately upon receipt of the invoice so that Medicaid coverage does not lapse.

EXAMPLE 1

Jerry is receiving MA D with a $250 spend-down. He gets a job and MADW is authorized on 10/20, after the adverse action date. The premium is $69 effective 12/1. The caseworker must notify Jerry that his spend-down for November is $69, and then access CUMED to change it to $69.

EXAMPLE 2

Mary is receiving MA D with a $50 spend-down. She gets a job and MADW is authorized on 10/12, before adverse action date. Her premium is $69 effective 11/1. Her MA D closes 10/31 and MADW is conditional. She must pay her premium before 11/1 so that her Medicaid health coverage does not lapse.

3455.09.00 M.E.D. WORKS CONTINUATION WHEN EMPLOYMENT IS LOST

If a M.E.D. Works recipient loses employment involuntarily due to being fired, laid off, or the employer closed the business, continuation of coverage is possible under the circumstance explained in this section. A person who quits a job or closes his own business is not entitled to M.E.D. Works coverage continuation. Additionally, M.E.D. Works can continue if the recipient goes on temporary medical leave, and his job is being held open by his employer. If a person goes on indefinite or long term disability status, he is not entitled to coverage continuation under this provision.

When employment is lost involuntarily, coverage continuation is possible if the recipient maintains an attachment to the workforce under one of the following circumstances:

Enrollment in a Vocational Rehabilitation Program;

Enrollment or registration with the Department of Workforce Development;

Participation in a transition from school to work program;

Participation with an approved provider of employment services.

When the recipient reports that he is no longer working, the caseworker must ask him if he is or will remain attached to the workforce under one of the above circumstances. If the recipient is otherwise eligible, and states that he will participate in one of the workforce attachment activities, the caseworker is to enter the activity on ICES and give the recipient Form 2032, Pending Verifications stating that documentation of the workforce attachment must be submitted within 60 days of the date that person stopped working. The documentation must be from the agency or service provider with whom the recipient is registered/enrolled. In the situation of medical leave, the recipient must provide a statement from the employer that the medical leave is temporary and the job is being held open for the recipient. If the recipient does not provide this documentation within 60 days after the employment ended, he is no longer entitled to M.E.D. Works. Eligibility must be explored for the other Medicaid categories.

If the recipient provides the initial documentation of workforce attachment, continued verification is required quarterly. The recipient is entitled to 12 months of coverage continuation. If, after 12 months, he is not working, he is no longer eligible for M.E.D. Works. Eligibility under the other Medicaid categories must be considered.

3455.10.00 ELIGIBILITY UNDER THE SPEND-DOWN PROVISION (MED 1, 2)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance. Within MED 2, the policies apply only to MA Q.

If a surplus income results from the eligibility budget, the AG will pass financial eligibility only if allowable medical expenses incurred by the applicant/recipient and his spouse or parent whose income is included in the budget, exceed the surplus income. (f55a) The surplus, rounded down to the

next whole dollar, is the AG's income spend-down. Refer to Sections 3440.46.00 and 3440.46.05 regarding allowable medical expenses in the Medicaid budget. If an individual pays a health insurance premium, the amount of the premium is deducted from the gross spend-down (before premium deduction) to determine the net spend-down (after premium deduction). The net spend-down is the amount that will be known to the recipient as the spend-down.

Eligibility for the three months prior to the month of application is based on actual expenses incurred in each of those months. Continuing spend-down status is established from the month of application forward, based on the best estimate of ongoing and/or anticipated medical expenses. Expenses incurred prior to the Medicaid covered period for which the applicant/recipient remains liable, are allowable in the eligibility determination. Refer to Section 3440.47.00 regarding procedures for entering medical expenses in ICES including the unpaid balance of "old bills".

Individuals who are approved with a spend-down have access to Medicaid covered services on the first day of every month in which they are enrolled. The spend-down works like an insurance deductible. Medical providers file their claims for services and the spend-down amount is deducted from their payment. If the recipient has Medicare or other third party insurance, the provider must bill the third party first. The recipient’s out of pocket cost satisfies spend-down. Certain expenses, referred to as non-claims because they cannot be filed directly to the AIM system, must be submitted to the local office. Refer to Chapter 3600 for information on the monthly process to satisfy spend-down.

3455.15.00 POST-ELIGIBILITY BUDGETING (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

A post-eligibility budget is to be completed for the individual who passes the eligibility determination and is in a Medicaid certified long term care (LTC) facility or hospital. Post-eligibility is not completed for the individual who resides in his home or in a non-Medicaid certified facility. Also, a post-eligibility budget is not completed for the individual who is disapproved for nursing home placement (Level of Care or Preadmission Screening denial) or who is serving a transfer of property penalty. When a M.E.D. Works recipient is subject to post-eligibility budgeting in a Medicaid facility, there is no premium charged.

The beginning month of the post-eligibility budget differs depending on whether or not the applicant is subject to the

"spousal impoverishment" provisions; for example, the applicant is in an LTC facility and has a community spouse. In these situations, the post-eligibility budget begins with the first month of continuous institutionalization. (Refer to Section 2635.10.10 for further information about continuous periods of institutionalization in spousal impoverishment cases.)

For applicants not subject to spousal impoverishment provisions, the post-eligibility budget is completed when the applicant is institutionalized for a full calendar month. If the applicant enters a facility on the first day of the month, post-eligibility begins with that month. If the applicant enters on a day other than the first, post-eligibility begins with the month following the month of admission.

When a recipient enters a Medicaid certified LTC facility from his home, the post-eligibility budget is completed in accordance with the instructions in Chapter 2200 regarding changes in circumstances. However, the post-eligibility budget can begin no earlier than the month following the month of admission.

For recipients who are discharged from an LTC facility, the eligibility budget is applicable in the month following the month of discharge in accordance with change processing guidelines in Chapter 2200.

When a recipient enters a hospital from his home the Local Office will have to determine the anticipated length of his hospital stay. If it is expected that the hospital stay will continue for at least a full calendar month, a post-eligibility budget is required in accordance with change processing requirements in Chapter 2200.

It is a general rule that the surplus income from the post-eligibility budget is a "liability" and the surplus income from an eligibility budget is a "spend-down". However, there are the following exceptions:

> A liability can only be designated for the individual who is residing in an LTC facility. It is the amount which Medicaid will not pay to the facility each month.
>
> If the individual is in a hospital, the surplus resulting from the post-eligibility budget is a "spend-down" subject to the provisions in Section 3455.10.00 and Chapter 3600.

Whenever a LTC recipient enters a hospital the facility is to collect the liability in the usual manner and apply it toward the nursing home charges for the month. Any

remainder is to be shown as a credit on the recipient's account and applied toward subsequent month(s)' charges.

The post-eligibility budget is displayed on screen AEBPL.

3455.15.05 Exempt Income In Post-Eligibility Budgeting (MED 1)

In post-eligibility, the total income of the individual who is institutionalized is counted except as specified below:

SSI payments made to a recipient who is in 1619 status who enters a Medicaid certified facility will not be reduced to $30 and are not to be counted as income for the first two full months of institutionalization. (f56)

The SSI payments made for 90 days to recipients who are temporarily institutionalized are exempt. The SSA issues a special notice to these recipients indicating they are receiving benefits under P.L. 100-203. The Local Office must retain a copy of this notice in the recipient's casefile, unless it is verified on DESX.

The maximum SSI payment for a recipient in a Medicaid certified facility is $30 unless he is receiving benefits under P.L. 100-203. However, the full benefit amount may be erroneously paid for a few months to an individual just entering a facility. These erroneous payments are exempt if documentation is provided that the individual has repaid SSI for benefits received before the reduction to $30. Otherwise they are budgeted as income in post-eligibility.

The reduced VA benefit of $90 payable to a veteran or veteran's widow in a Medicaid certified facility is exempt. (f57)

German reparation payments are exempt. (f58)

3455.15.10 Deductions From Income In Post-Eligibility (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

The deductions listed below are to be subtracted from the applicant's/recipient's non-exempt income.

The standard personal needs allowance (Section 3010.20.10) is deducted.(f59) This allowance can be spent by the individual in any way he chooses. If a veteran or veteran's widow is receiving the $90 reduced pension and has another

source of income, the individual is not entitled to an additional personal needs allowance.

In the specific situations explained below an additional amount for increased personal needs is to be deducted:

Sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted in a special manner. Note that this deduction is called an increased personal need in Indiana's approved Medicaid State Plan; however, it is reflected in the computation of net earned income as explained in Section 3455.15.10.05.

Court ordered guardianship fees paid to the applicant's/recipient's legal guardian, not to exceed $35 per month, are to be deducted. Guardianship fees include all services and expenses required to perform the duties of a guardian. Within this context, attorney fees would be included as a guardianship fee.

Federal, state and local taxes on the applicant's/recipient's unearned income which are owed and paid are to be deducted. This deduction is allowable on a one-time basis per year in the next month after the applicant/recipient provides documentation of the payment of the annual tax liability on unearned income. Enter the amount paid as a deduction from income on AEFUD. The correct code is "IT-Income taxes paid by person in institution". The worker must then be sure to remove the deduction for the following month.

A spousal allocation as explained in Section 3455.15.10.10 is deducted.

A family allocation as explained in Section 3455.15.10.15 is deducted.

Health insurance premiums which the applicant/recipient pays for his health insurance coverage (including Medicare prior to Buy-In) is deducted from his income. If the premium is paid less often than monthly, it is to be prorated over the appropriate number of months. This deduction is only allowed for health insurance policies which limit the benefits and the purposes for which the benefits can be used to pay for medical care. Premiums for indemnity policies are not allowed.

Medical expenses which are not subject to payment by a third party and are not covered by Medicaid are deducted, except nursing facility expenses incurred during an imposed transfer of property penalty. These expenses incurred during a transfer penalty are not allowed beginning 7-01-03 regardless of when the transfer penalty was imposed. Prescription drugs not covered by Medicare Rx are allowed as deductions in post-eligibility if Medicaid does not cover them.

The local office will allow a deduction for an incurred medical expense not covered by Medicaid and not subject to payment by Medicare or other insurance, if an actual provider-generated bill, or copy of such a bill, is submitted to the caseworker. This bill must indicate the date and type of service that was provided and must clearly show the amount that the recipient owes after any third party has paid. If the recipient has third party insurance that does not show as a payer on the bill, the recipient or provider must submit either an EOB documenting denial of payment or some other documentation of why the insurance was not billed or did not pay. No other documentation is acceptable. Local Offices are not to sign any documents or "agreements" to "deviate the liability". If proper documentation is submitted, the expense is to be entered on ICES as code NM and it will be deducted in the post-eligibility calculation. The caseworker is to enter reason code 066 when authorizing the reduction/elimination of the patient liability. If it takes more than one month to meet the expense, caseworkers must have fail-safe monitoring procedures to ensure that the expense is removed at the proper time. CUMED is not to be used for this purpose unless it is necessary to correct an error made by the caseworker, that for some reason cannot be accommodated in future months. Recipient change reporting guidelines apply to institutionalized recipients in the same manner as other recipients.

3455.15.10.05 Sheltered Workshop Earnings/Post Eligibility (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

Sheltered workshop earnings and earnings which are part of a habilitation plan are included as earned income. In the eligibility step, sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted exactly the same as any other earned income from employment. The standard earned income disregard is applicable.

In the post-eligibility step, the net income after allowing employment expenses is divided by two to determine the net countable income. (f60) Employment expenses are as follows:

$16 employment incentive;

State, local and federal income taxes, including FICA. The amount to be deducted is based on monthly income by using the appropriate state and federal tax charts. The tax deduction is to be determined by using the total number of exemptions to which the applicant/recipient is legally entitled, whether or not they are actually claimed for withholding purposes.

Transportation expenses. A deduction is allowed for expenses directly related to the earning of income. The actual documented expense is allowed for a transportation carrier; $.15 per mile is allowed if the individual drives his own automobile to and from work.

The above listed deductions, including the $16 disregard, must be computed manually and entered on AEINC. For each of the three retroactive months, enter one deduction amount in the "DED" field. After the screen re-appears with the converted 'monthly income' amount displayed, calculate the ongoing deduction using that income amount and enter it in the 'deductions' field. ICES will then compute the earned income to be counted in the post-eligibility budget. It will be displayed as earned income on screen AEBPL.

3455.15.10.10 Spousal Allocation Deduction (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

In the post-eligibility determination of an institutionalized applicant/recipient with a community spouse, an allocation to the community spouse must be computed. The spousal allocation is the amount by which the spousal maintenance standard exceeds the community spouse's countable income. The spousal allocation is determined as follows:

The income designated as owned by the community spouse is identified and entered on the appropriate ICES screens.

The total gross income of the community spouse is established.

The amount, if any, of the excess shelter allowance is computed. This is the amount by which the sum of the community spouse's expenses for shelter and utilities exceeds the shelter standard. Allowable shelter expenses include:

rent or mortgage;

property taxes;

insurance;

maintenance charge on condominium.

Allowable utility expenses include:

basic telephone rate.

gas, electricity, water, oil, sewerage, trash collection.

The community spouse's actual utility expenses are budgeted unless the community spouse chooses the standard utility allowance (SUA) option. If the SUA option is chosen, the appropriate standard utility allowance will be budgeted. For an explanation of the SUA, refer to the following Food Stamp sections:

3440.15	- Utility Deduction Options
3440.15.10	- Standard Utility Options Available
3440.15.10.05	- Switching A Utility Option
3440.15.20	- Caseworker Responsibilities Regarding Utilities
3440.15.25	- Entering Utility Deductions in ICES

The spousal income standard and the excess shelter allowance are added, thus arriving at the spousal maintenance standard. The spousal maintenance standard cannot exceed the maximum.

If the community spouse's countable income is equal to or greater than the maintenance standard, there will be no allocation from the income of the applicant/recipient.

If the spouse's countable income is less than the maintenance standard, the difference between the two amounts is the amount of the spousal allocation to be deducted from the income of the applicant/recipient.

If a court has ordered an institutionalized spouse to pay a monthly amount for the support of the community spouse, the monthly spousal allocation cannot be less than the court ordered support.

If a hearing decision results in a revision of the spousal allocation, the additional amount must be budgeted as long as the exceptional circumstances upon which the increase is based continue to exist. Refer to Chapter 4200 regarding appeals.

The spousal allocation from the institutionalized spouse's income will be budgeted only to the extent that it is actually made available to the community spouse. In situations when the community spouse is an applicant/recipient, the amount of the total allocation may impose a spend-down for the community spouse or cause ineligibility for cash assistance and/or Medicaid. When these situations occur, the spouses can arrange for a lower allocation or none at all. The allocation can be modified by the caseworker on AEIII.

The spousal allocation is displayed on the budget screen AEBPL.

3455.15.10.15 Family Allocation Deduction (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

The following family members may receive an allocation from the institutionalized applicant/recipient if they live with the community spouse and are entered on screen AEIHH. (The allocation is deducted from the institutionalized applicant's/recipient's income regardless of whether or not it is actually given to the family member):

Biological or adoptive children of either spouse who are under 21 and living with the community spouse.

Biological or adoptive children age 21 or over who are claimed as tax dependents by either spouse and living with the community spouse.

Parents of either spouse who are claimed as tax dependents and living with the community spouse.

Biological or adoptive siblings of either spouse who are claimed as tax dependents and living with the community spouse.

The family allocation, for each family member, is calculated as follows:

Subtract from the spousal income standard the countable income of the family member. (Note: an allocation is not permissible if the family member's countable income equals or exceeds the spousal income standard.)

Divide the difference by three. The resulting amount is the family allocation.

Repeat the previous two steps for each appropriate family member to arrive at the total family allocation to be deducted from the income of the institutionalized applicant/recipient.

3455.15.15 Liability Exceeds Facility Private Rate (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

If the liability amount calculated in the post-eligibility determination exceeds the facility's private rate, the AG is subject to the spend-down provision in Chapter 3600. Only the medical expenses of the recipient count toward meeting his spend-down. In this situation, screen AEBPL will display the message "Ongoing spend-down".

3455.15.15.05 Liability Exceeds Medicaid Rate (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

An applicant/recipient residing in a long term care facility who has a liability greater than the facility's Medicaid rate but less than the private rate, is not eligible for Medicaid reimbursement of the facility's per diem. The applicant/recipient is eligible for payment of all other Medicaid services, including the facility's ancillary charges.

The facility will collect the individual's liability and apply it toward the private pay rate. The facility can bill the Medicaid program for all covered services except the per diem.

3455.15.20 Medicare Involved In Nursing Facility Payment (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

When Medicare or other insurance covers the nursing home per diem charges for an entire month, or partial month when the non-Medicare covered charges are less than the liability, the eligibility budget is to be used. The facility charges

which are covered by Medicare or other insurance are not allowable medical expenses for spend-down purposes and are not entered on screen AEFME.

3455.20.00 FINANCIAL ELIGIBILITY FOR RBA-RELATED MEDICAID (MED 1)

When an individual has been determined to be eligible for Room and Board Assistance (RBA), the individual is financially eligible for Medicaid. There is no budget for Medicaid eligibility purposes.

When the caseworker determines that the individual is eligible for RBA, a "Y" should be entered in the 'RBA ELIG' field on AEIIM.

On screen AEIII enter "N" in the response field for the question regarding Medicaid certification of the institution, since an RBA facility is not Medicaid certified. The liability to the RBA facility is not a Medicaid liability and is not computed by ICES or entered into the system. It is computed manually by the caseworker in accordance with instructions in the Public Assistance Manual for State Assistance Programs, Section 335.

3455.25.00 BUDGETING INCOME-IN-KIND (MED 1, MED 4)

The policies stated in this section apply only to the MA A, MA B, MA D, MA G, MA L, MA J, MA I, and MA K categories of assistance.

When someone pays for all of the applicant's/recipient's food, clothing, or shelter, income-in-kind is received. The amount to be budgeted as income is the actual value of the in-kind support and maintenance received not to exceed one-third of the applicable income standard. The one-third value is determined by dividing the income standard by three.

3460.00.00 BENEFIT CALCULATION (MED 2, MED 3)

The Medicaid financial eligibility determination compares the AG's countable income to the appropriate income standard for the category of Medicaid under consideration. Budgeting procedures are discussed in the following sections.

3460.05.00 MEDICAL ASSISTANCE BUDGETING (MED 2)

Eligibility for MA T, MA U, MA C, and MA M is based on the MED 2 income standard (see IPPM 3010.25.00). The various provisions for Medicaid coverage and the corresponding budgets are discussed in the following sections but the following rules apply to all MED 2 categories:

To determine entitlement for medical assistance first determine the income standard for the AG size and then the amount of countable income.

To calculate the amount of countable income the following rules apply: a parent's income can be used to determine his spouse's, and his child's eligibility; a child's income can be used to determine his own eligibility but not a sibling's or parent's eligibility.

To calculate a parent's countable income:

Determine the amount of the parent's gross income; or

if self-employed, deduct actual business expenses or 40% of the gross income as applicable.

Subtract applicable earned income deductions including:

Work expense disregard;

$30 and 1/3 disregard (MA C ONLY); and

out of pocket dependent care expense.

Allocation to a spouse who is not a member of the AG occurs only when the spouse does not have sufficient income to meet his needs. Allocation up to the full-standard to a child under age 18 who is not a member of the AG always occurs regardless of the child's income. If necessary, allocate to the parent's spouse or child by:

Determining the nonparticipating spouse's gross income;

subtracting the work expense disregard from earned income;

subtracting the total need standard of nonparticipating children in the home under age 18 who are solely the spouse's responsibility;

subtracting the total need standard of the nonparticipating spouse; and

subtract the total need standard of the non-AG child. (A parent allocates to his child regardless of the child's income.)

If the spouse has insufficient income to meet the needs of children who are solely his responsibility, the allocation equals the need standard of the nonparticipating spouse and common children.

The remainder of the parent's income, if any, is counted in the benefit calculation.

The parent's countable income is added to the participating child(ren)'s income. If the combined income exceeds the income standard, eligibility is determined by prorating the need standard among all AG members (participating and nonparticipating), allocating a parent's income to his children's unmet needs, and using each member's income and allocated income against his prorated share to determine that person's eligibility. In determining the amount of income a parent can allocate to a child these rules apply:

a) A parent's income is first used to meet their own needs.

b) Any remaining parental income is then used to meet the unmet needs of his spouse in the AG.

c) Any remaining income is then allocated equally between all of the parent's dependents with unmet needs.

   1) If this causes a surplus for a child, the surplus is divided equally among the remaining dependents with unmet needs up to the amount of that person's unmet needs.

   2) This will continue until all income is allocated or the needs of all individuals in the AG have been met.

If the child's prorated needs are met, the child is not eligible for medical assistance.

3460.05.05 Low Income Families (MA C) Support Extension (MED 2)

Low Income Families (MA C):

Medicaid eligibility due to receipt of child support:

When ineligibility for MA C is the result of the collection of new or increased spousal or child support, the AG may receive four months of continued MA provided the AG received MA C in three of the six months immediately preceding the

month of ineligibility.

Once the four month extension expires, eligibility for Medicaid for individual members of the AG must be determined.

Countable income and resources may not exceed the standards.

3460.05.20 TANF And Cash Assistance (MED 2)

TANF Recipients: Due to the Welfare Reform waiver provisions for TANF recipients may receive Medicaid Assistance but they must request Medicaid to receive the benefit. (f64)

Medicaid eligibility for the MA C category of assistance is based on the Cash Assistance determination.

Refugee:

All recipients of Refugee Cash Assistance are eligible for medical assistance. (f65)

Eligibility for the MA Q category of assistance is based on the Cash Assistance determination.

3460.05.25 Wards (MED 2)

Financial eligibility is based on TANF income and resource requirement. After 18 years of age a child who is a ward could be living with a specified relative and be eligible for Medicaid under the 18, 19, 20 year old provision. Refer to Section 3460.05.40.

3460.05.30 Refugees/Spend-Down Provisions (MED 2)

If a refugee is ineligible for Medicaid under any other category, he can be eligible for Refugee Medical Assistance (RMA) under the spend-down provision if his income exceeds the RCA Standard and his ongoing anticipated medical expenses exceed his surplus income.(f66)

3460.05.35 SSI Recipients

SSI recipients may receive MA provided all MA C eligibility requirements are met (except for the person's receipt of SSI). The AG determination for SSI recipients is as follows:

If the SSI person is a child, include the child's parents (no stepparents) and dependent siblings.

If the SSI person is a parent/caretaker, include the individual's spouse and dependent children.

3460.05.40 18, 19, 20 Year Olds (MED 2)

Children 18, 19, and 20 years old may receive Medical Assistance provided all TANF eligibility criteria are met except the age requirement. (f67)

The AG includes the dependent 18 - 21 year old and his dependent sibling(s) 18, 19 and 20 years old living in the home who are also applicants.

3460.05.45 Child In Psychiatric Hospitals (MED 2)

The AG determination for children in psychiatric hospitals include the child, the parent(s), and his dependent siblings (including half or adoptive) under 18 as if the placement did not exist.

However, the AG will be comprised of only the child in the following situations:

when the child is placed in the institution by a relative other than a parent and the child was not living with his parent(s) at the time of placement; or

the child is placed in the institution by court order or an agency legally exercising responsibility for the child and the parent does not currently maintain legal or physical care of the child.

Countable income and resources may not exceed the TANF standards.

3460.10.00 INCOME DEEMED FROM PARENTS OF A PREGNANT MINOR (MED 2, MED 3)

The nonexempt earned and unearned income of nonrecipient parents of the minor who is applying for or receiving pregnancy-related or full range pregnancy Medicaid is deemed from the nonrecipient parent of a minor mother when the unmarried minor lives in the home of her parent. Income is never deemed from a parent of minor when the minor parent is married.

3460.10.05 Income Deemed From A Parent Of A Pregnant Minor (MED 2, MED 3)

The policy stated in this section applies only to the MA N and MA M categories of assistance.

When determining Medicaid eligibility for a pregnant minor, the income of her parents living in the home must be deemed

available to her. Income is NOT deemed when the minor is married.

There are three general rules which apply to the deeming process:

There is no allocation to any of the pregnant minor's siblings or half-siblings who receive SSI;

A dependent child is any sibling or half-sibling of the pregnant minor under age 18;

Any earned or unearned income received by a sibling or half-sibling of the pregnant minor is disregarded in the eligibility determination.

The calculations for determining the amount to be deemed to the MP/LP AG are outlined in the following sections.

3460.10.10 Income Deemed From One Parent With No Spouse (MED 2, MED 3)

When deeming income from a parent of a pregnant minor, the amount of deemed income to be counted in the benefit calculation is determined as follows:

Determine the amount of the parent's nonexempt gross income;

If self-employed, deduct annual business expenses or 40% of the gross income as applicable;

Subtract the $90 work expense disregard from earned income. Subtract any mandatory deductions actually being withheld from the unearned income;

Subtract spousal or child support payments made by the parent to individuals outside of the home;

Subtract the income standard of the parent and his children in the home under age 18;

The remainder of the income, if any, is counted in the benefit calculation.

3460.10.15 Income Deemed From One Parent With Spouse (MED 2, MED 3)

When deeming from a married parent of a minor parent with a spouse in the home, the amount of deemed income to be counted in the benefit calculation is determined as follows:

Determine the amount of the parent's gross income;

If self-employed, deduct annual business expenses or 40% of the gross income as applicable;

Subtract the $90 work expense disregard from earned income. Subtract any mandatory deductions actually being withheld from the unearned income;

Subtract child or spousal support payments made by the parent to individuals outside of the home;

Subtract the income standard of the parent and nonparticipating children under age 18 in the home who are solely the parent's responsibility;

Subtract an amount equal to the income deficit of a nonparticipating spouse of the parent and common children under age 18. To determine the spouse's available income and verified unmet needs:

- determine the nonparticipating spouse's gross income;
- subtract the $90 work expense disregard from earned income;
- subtract the total need standard of nonparticipating children in the home under age 18 who are solely the spouse's responsibility;
- Subtract the total need standard of the nonparticipating spouse and common children under age 18.

  If the spouse has insufficient income to provide for children who are solely his responsibility, the parent's allocation equals the income standard of the nonparticipating spouse and common children.

The remainder of the income, if any, is counted in the benefit calculation.

3460.10.20 Income Deemed From Two Parents (MED 2, MED 3)

When deeming income from two parents living in the home who both have income, the amount of deemed income to be counted in the benefit calculation is determined as follows:

Determine the amount of each parent's gross income;

If self-employed, deduct annual business expenses or 40% of the gross income as applicable;

Subtract the $90 work expense disregard from earned income. Subtract any mandatory deductions actually being withheld from the unearned income;

Subtract spousal or child support payments made by each parent for individuals outside of the home from that parent's income.

Subtract from each parent's income the income standard of nonparticipating children in the home under age 18 who are solely that parent's responsibility;

Add together both parents' remaining income;

Subtract the income standard of both nonparticipating parents and common children under age 18;

The remainder of the income, if any, is counted in the 185% test and benefit calculation.

3460.15.00 MEDICAL ASSISTANCE (MED 3)

The policy stated in this section applies to the MA Y, MA Z, MA 2, MA 9, MA 10 and MA N categories of assistance.

To determine Medicaid benefit entitlement:

To determine entitlement for medical assistance first determine the income standard for the AG size and then the amount of countable income.

In calculating the amount of countable income the following rules apply: A parent's income can be used to determine his/her spouse's and his child's eligibility; and child's income can be used to determine his eligibility but not a sibling's or parent's eligibility.

To calculate a parent's countable income:

Determine the amount of the parent's gross income;

If self-employed, deduct actual business expenses or 40% of the gross income as applicable;

Subtract applicable earned income deductions including:

$90 work expense disregard; out of pocket dependent care expense;

Allocation to a spouse who is not a member of the AG occurs only when the spouse does not have sufficient income to meet his needs.

Allocation to a child under age 18 who is not a member of the AG always occurs regardless of the child's income. If necessary, allocate to the parent's spouse or child by:

Determining the nonparticipating spouse's gross income;

subtracting the work expense disregard from earned income;

subtracting the total need standard of nonparticipating children in the home under age 18 who are solely the spouse's responsibility; and

subtracting the total need standard of the non-AG child. (A parent allocates to his child regardless of the child's income.)

If the spouse has insufficient income to meet the needs of children who are solely his responsibility, the allocation equals the need standard of the nonparticipating spouse and common children.

The remainder of the parent's income, if any, is added to the participating child(ren)'s income. If the combined income exceeds the income standard, eligibility is determined by prorating the need standard among all AG members (participating and nonparticipating), allocating a parent's income to his children's unmet needs, and using each member's income and allocated income against his prorated share to determine that person's eligibility. In determining the amount of income a parent can allocate to a child these rules apply:

a) A parent's income is first used to meet their own needs.

b) Any remaining parental income is then used to meet the unmet needs of his spouse in the AG.

c) Any remaining income is then allocated equally between all of the parent's dependents with unmet needs.

   1) If this causes a surplus for a child, the surplus is divided equally among the remaining dependents with unmet needs up to the amount of that person's unmet needs.

2) This will continue until all income is allocated or the needs of all individuals in the AG have been met.

There are no resource limits for these programs.

There are no financial eligibility requirements or budget calculations for the MA E category of assistance.

3465.00.00 BENEFIT CALCULATION (MED 4)

Financial eligibility for the Qualified Medicare Beneficiary (QMB), Qualified Disabled Worker (QDW), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individual's (QI) programs is determined by comparing the countable income of the AG to the appropriate income standard. Refer to Chapter 3000 for the income standards.

3465.05.00 QMB/QDW/SLMB/QI BUDGETING PROCEDURE (MED 4)

The earned and unearned income of the AG is considered in the eligibility determination of an individual who qualifies for Medicare Part A and who meets other resource and nonfinancial requirements. The AG consists of the applicant/recipient and his spouse when they are living together, and the applicant's/recipient's dependent biological, adoptive, and step child(ren) in the home whose monthly income is less than the applicable income standard. The applicant's/recipient's essential person whose monthly income is less than the applicable income standard is also considered in the AG.

Income that is disregarded according to instructions in Chapter 2800 is not considered. Also, child support payments made by the spouse of an applicant/recipient in compliance with a court order or Title IV-D are disregarded.

A general income disregard of $20 is allowed for the AG. This disregard is to be applied only once to a couple even when both members have income. It is applied to both earned and unearned income, but must be deducted first from unearned income. (f68)

A general earned income disregard of $65 is next allowed from the total of the couple's net self-employment income and other earned income. One-half of the remainder is also disregarded. Additionally, the earned income disregard is applied to the earned income of any other member of the AG. Special sheltered workshop budgeting does not apply to the institutionalized applicant/recipient.

From the total countable income of the AG, any income of a disabled individual (or the individual's spouse) which has been set aside under an approved plan for achieving self-

support (PASS) is also disregarded. Refer to Section 3455.05.05.15.

> NOTE: The Social Security COLA received annually in January is disregarded until April of the same year (three months disregard). Refer to Section 3455.05.05.10.

The total countable income of the AG is compared to the applicable income standard for the AG's family size. If the countable income equals or is less than the appropriate income standard, the applicant/recipient is financially eligible. There is no spend-down provision in the determination of eligibility under these categories.

QMB eligibility begins with the month following the month of the QMB eligibility determination.

QDW eligibility begins with the effective date of the Premium Part A but no earlier than three months prior to application. The effective date for a Medicaid recipient who is already bought in is the first day of the month following Medicaid termination. An applicant/recipient is not eligible for QDW if he is otherwise eligible for Medicaid. (f69)

SLMB and QI eligibility can begin no earlier than the first of the third month prior to the month of application.

3475.00.00 <u>1619 MEDICAID BUDGETING</u> (MED 1)

The policies stated in this section apply to the MA A, MA B, and MA D categories of assistance.

Section 1619 of the Social Security Act provides an incentive to the blind or disabled SSI recipient to continue work when his earned income reaches levels that would otherwise jeopardize eligibility. Individuals in 1619(a) status receive reduced SSI benefits, while individuals in 1619(b) status receive no SSI benefits. Blind or disabled SSI recipients who are in 1619(a) or 1619(b) status for SSI purposes can be eligible for continued Medicaid coverage without regard to any Medicaid eligibility requirements, except residency. Special 1619 Medicaid coverage is granted if the recipient was on Medicaid in the month immediately preceeding the month in which the individual's 1619 status last began.(f73) There is no requirement to meet a spend-down in the month prior to entering 1619 status. Special 1619 Medicaid coverage continues as long as the recipient's 1619 SSI status is in effect. If the residency requirement is met, all other Medicaid eligibility requirements, including income and resources, are suspended while the individual remains in 1619. However, the special exclusion of income applies only in the eligibility step, not to the

post-eligibility budget of recipients in Medicaid facilities.

SSI payments made to recipients who are in 1619 status and who enter public institutions and Medicaid certified facilities (hospital, ICF, SNF, ICF/MR, or CRF) are not reduced to the $30 cap for the first two full months of institutionalization. These SSI payments are disregarded as income in the Medicaid eligibility determination and are disregarded as income in the post-eligibility budget of the individual only in the first two full months of institutionalization.(f74)

If a progress report is due for a disabled person who has 1619 status, the Medicaid Medical Review Team (MMRT) should be notified of the recipient's 1619 status. If 1619 status is subsequently lost, a progress report must be submitted immediately to the MMRT. If a re-examination of eyesight is required for a blind recipient in 1619 status, notification to the MMRT is unnecessary. However, an eye report is required immediately upon termination of 1619 status.

A recipient's 1619 status is verified through data exchange. ICES automatically updates an individual's SSI status on the AEIDC screen and notifies the caseworker of the update through an alert.

3480.00.00 BUY-IN PROCEDURES AND EFFECTIVE DATES (MED)

Buy-In is the process by which the state pays the Medicare premium for Medicaid recipients.

To add a person who has Medicare Part B to Buy-In, complete the Medicare Part B information on screen AEFMC for each individual. Be sure that the sequence number of the individual whom you enter as the policyholder is that of the Medicare/Medicaid recipient and matches the sequence number of the person listed at the bottom of the screen in the lower left corner in the "relationship" area. Use PF1 key for further assistance in completing the screen. The Buy-In effective date should be left blank on screen AEFMC. When Buy-In occurs, ICES will add the Buy-In effective date and the VR code of "DE".

The premium amount of Medicare Part B being paid by the individual should always be entered as a medical expense on screen AEFME. When Buy-In occurs, the system will change the expense type from "self pay" to "bought in" and will change the liability amount for recipients in Medicaid facilities.

The AIM System will determine the Buy-In effective date and transmit the date to ICES on AEFMC. For information

purposes, the determination of the Buy-In effective date is explained below.

For money grant recipients, the Medicare Part B Buy-In effective date is determined as follows:

Recipients are considered to be money grant recipients if they receive all or any part of their monthly income from any of the following sources:

SSI (Supplemental Security Income);
TANF (Temporary Assistance For Needy Families)
or RBA (Room and Board Assistance)

The Part B Buy-In effective date for money grant recipients, regardless of QMB status, is the latest of the following dates:

Medicaid effective date;
Medicare effective date; or
Money-grant effective date.

For non-money grant recipients, Medicare Part B Buy-In effective date is determined as follows:

for new Medicaid AGs, the Part B Buy-In effective date for non-money grant, non-QMB recipients is the second month following the month in which the caseworker authorized the recipient's Medicaid eligibility.

EXAMPLE:

On 10/5 Ann Smith is determined eligible for Medicaid retroactive to 6/1. She began receiving Medicare on 5/1. Part B Buy-In effective date is 12/1, the first day of the second month following the month in which her Medicaid eligibility was authorized.

For new, non-money grant, QMB recipients, the Part B Buy-In effective date is the QMB effective date established by ICES.

For a continuing Medicaid AG, the Part B Buy-In effective date is the first of the month in which the Medicaid recipient's Medicare eligibility begins, regardless of the money grant or QMB status.

For SLMB and QI recipients, the effective date of Medicare Part B Buy-In is the date of eligibility for SLMB or QI. It will be no earlier than the first of the third month prior to the month of application.

Individuals who apply for Medicaid and are not receiving Medicare although they are entitled to it, must be advised to contact SSA and apply. When the Medicare application is approved and the worker has documented it, Buy-In can take place. Complete screen AEFMC for Medicare Part A and Part B.

If an individual has applied for Medicare at the SSA but is not receiving Part B, Buy-In will be accomplished by ICES in the usual manner.

The Medicare Part A Buy-In effective date is determined by ICES. The system will determine a Part A Buy-In effective date if the QMB or QDW recipient's Medicare claim number (HIB) listed on screen AEFMC ends in "M". The "M" means that the person is not eligible for free Medicare Part A but must pay a premium for it. It is referred to as "Premium Part A" by the SSA. The QMB or QDW effective date established by ICES also determines the Part A Buy-In effective date.

To enroll a person in Medicare Part A Buy-In, complete screen AEFMC for Medicare Part A just as for Medicare Part B. If the individual does not already have Medicare Part A, the policy "Begin Date" will equal the QMB or QDW effective date. Do not complete the Part B Buy-In effective date.

If the individual is a QDW, also complete the QDW information line by marking "Y" after QDW, then entering the QDW effective date as the "Prem Part A Beg". Do not make an entry in the "End" field.

3499.00.00 FOOTNOTES FOR CHAPTER 3400

Following are the footnotes for Chapter 3400:

(f1) 7 CFR 173.10(c) - F;
405 IAC 2-5-1(a)(6) - MED
(f1a) 405 IAC 2-5-1(b)
(f2) 7 CFR 273.10(a)(2) - F;
405 IAC 2-5-1(a)(1) - MED
(f3) 7 CFR 273.11(a)(4)
(f4) 470 IAC 10.1-3-4
(f5) 405 IAC 2-3-3
(f6) 7 CFR 273.11(b)
(f7) 7 CFR 273.1(g)
(f8) Higher Education Amendments of 1992, P.L. 102-325
(f9) 45 CFR 233.20(a)(3)(ii)(F)
(f10) 45 CFR 233.20
(f11) 470 IAC 10.1-3-6
(f12) 470 IAC 10.1-3-6
(f13) 470 IAC 10.1-3-6
(f14) 470 IAC 10.1-3-6
(f15) P.L. 103-66, Mickey Leland Childhood Hunger Relief

	Act
(f16)	Social Security Act, Section 402(a)(8)(A)
(f17)	7 CFR 273.9(d)(6)
(f18)	7 CFR 273.9(d)(5)
(f19)	7 CFR 273.9(d)(3) – F
(f19a)	405 IAC 2-3-10
(f20)	7 CFR 273.10(d)(1)(i)
(f21)	7 CFR 273.10(d)(2)
(f22)	7 CFR 273.10(d)(5)
(f23)	7 CFR 273(d)(1)
(f24)	7 CFR 273.9(d)(2)
(f25)	7 CFR 273.10(a)(1)(ii)
(f25a)	7 CFR 273.2 (h)(2)(ii)
(f26)	7 CFR 273.11(c)
(f27)	7 CFR 273.11(j)
(f27a)	P.L.104-193, Personal Responsibility and Work Opportunity Reconciliation Act, Section 829
(f27b)	7 CFR 273.11(k)
(f28)	Social Security Act, Section 402(a)(18); 45 CFR 233.20
(f29)	IC 12-1-7-3
(f30)	45 CFR 233.20
(f31)	Social Security Act, Section 402(a)(8); 45 CFR 233.20
(f32)	45 CFR 233.20 470 IAC 10.1-3-5
(f33)	Social Security Act, Section 402(a)(34); 45 CFR 233.20
(f33a)	SSA 1931(b)(2)(C) as added by Sec 114(a) as amended by Indiana Amended Waiver Terms and Conditions, Section 2.6
(f34)	45 CFR 233.20 as amended by OBRA-93
(f35)	Social Security Act, Section 402(a)(31); 45 CFR 233.20
(f36)	45 CFR 233.20
(f37)	Simpson et al v. Hegstrom et al Court of Appeals, 9th Circuit
(f38)	45 CFR 233.20; 470 IAC 10.1-3-4
(f39)	45 CFR 233.20 as amended by OBRA-93
(f41)	Social Security Act, Section 415; 45 CFR 233.51
(f42)	Social Security Act, Section 415; 45 CFR 233.51
(f43)	45 CFR 233.20; Social Security Act, Section 402(a)(32)
(f44)	45 CFR 233.20; Social Security Act, Section 402(a)(32)
(f45)	405 IAC 2-3-20
(f46)	42 CFR 435.134
(f47)	Social Security Act, Section 1905(p)(2)(D) as amended by OBRA-90
(f48)	405 IAC 2-3-3
(f49)	405 IAC 2-1-1

(f50) 405 IAC 2-3-20(b)
(f51) 405 IAC 2-1-1
(f52) 405 IAC 2-3-20
(f53) 405 IAC 2-3-19
(f55) IC 12-15-41-9
(f55a) 405 IAC 2-3-10
(f56) Social Security Act, Section 1611(e)(1)(E); Public Law 99-643
(f57) Section 3203 of Title 38 USC as amended by OBRA-90 (P.L. 101-508)
(f58) Social Security Act, Section 1902(r)(1) as amended by OBRA-90 (P.L. 101-508)
(f59) 405 IAC 2-3-17; 405 IAC 2-3-21
(f60) IC 12-15-7-4
(f61) 42 CFR 435.113
(f62) 42 CFR 435.602
(f63) 42 CFR 435.113; Reed v Blinzinger, U.S. District Court, IP 85-1385-C
(f64) 42 CFR 435.110
(f65) 45 CFR 400.100
(f66) 45 CFR 400.103
(f67) 405 IAC 2-6-1
(f68) Social Security Act, Section 1905(p)(1)
(f69) Social Security Act, Section 1905(s)(4) as amended by P.L. 101-239)
(f73) Social Security Act, Section 1619(b)(3)
(f74) Social Security Act, Section 1611(e)(1)(E); Public Law 99-643